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Governing Health

Transformations in the Turkish Health Care System

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Governing Health

Transformations in the Turkish Health Care System

STEFAN KOHLWES

Die (vergleichende) Wohlfahrtsstaatforschung neigt zum Gebrauch absoluter Kategorien wie „Staat", „Markt", „Klasse" oder „Soziale Gerechtigkeit", um die Entstehung und Entwicklung von Wohlfahrtsstaaten zu erklären, zu messen oder zu kategorisieren. Insbesondere auf der Grundlage der Arbeiten Michel Foucault's zum Thema Gouvernementalität versucht diese Masterarbeitarbeit, alternative Perspektiven auf die Transformation von Wohlfahrtsstaaten zu bieten und die Entwicklungen in ihrer historischen Gebundenheit und der Komplexität der sich in ihnen widerspiegelnden sozialen Beziehungen zu verstehen. Dafür werden Episoden türkischer Gesundheitspolitik seit dem späten Osmanischen Reich interpretiert. Die Kernthemen sind die sich ändernde politischen Vorstellungen von Gesundheit einerseits und andererseits Techniken und Strategien, die politische Akteure anwenden, um das Politikfeld Gesundheit zu strukturieren und das Verhalten relevanter Akteure zu steuern. Die Arbeit greift insbesondere auf Primärquellen, wie offizielle Regierungspapiere, Reden, oder Leitfadeninterviews mit Experten zurück. Die Analyse zeichnet den politischen Diskurs über Gesundheit(spolitik) nach, der von „Barmherzigkeit und Gnade" über die „Sicherung der Stärke der Nation" bis hin zu der Idee eines „Rechtes auf Gesundheit" reicht, welche seit den 1980er Jahren durch neoliberales Vokabular wie „(minimaler) Universalismus", „Eigenverantwortung" oder „Effizienz und Wettbewerb" ergänzt wird. Derweil blieben trotz der Entstehung und Ausdehnung des Politikfeldes mit zugeordnetem bürokratischen Apparat, viele Programme und Projekte aufgrund der gesellschaftlichen und wirtschaftlichen Struktur sowie fortlaufender Konflikte zwischen unterschiedlichen Regierungsmentalitäten inkonsistent und unvollendet. Erst mit dem sogenannten Health Transformation Program, das seit 2003 unter der Partei für Gerechtigkeit und Fortschritt (AKP) implementiert wird, scheint ein Gesundheitssystem entstanden zu sein, welches sich durchgängig auf eine neoliberale Regierungslogik bezieht und die formalen Prinzipien einer Marktwirtschaft als Regierungsprinzip auf die Erstellung von Programmen, Projekten und Regulierungen im Gesundheitssektor projeziert.

Stichworte: Türkei, Wohlfahrtsstaat, Gouvernementalität, Sozialpolitik, Gesundheitswesen, Türkische Sozialpolitik, Neoliberalismus

Scholars of the welfare state tend to use absolute categories such as "class", "state", "market" or "social justice" to measure, classify and compare welfare states. Drawing predominantly on Michel Foucault's lectures on governmentality, this master's thesis attempts to offer alternative perspectives on the transformation of welfare states by analyzing developments in the Turkish health system in consideration of their historicity and of the complexity of social relations reflected in them. Interpreting different historical episodes of Turkish health policies since the late Ottoman Empire, special attention is paid not only to changing political conceptions of health, but also to the techniques and strategies that governments have relied on to influence the conduct of providers and receivers of health services. The study draws predominantly on primary sources such as official government papers, speeches and expert interviews. Dominant political discourses on health have reached from "charity and favor" under the Sultans over "securing the strength of the nation" in the early Republic to the idea of everybody's "right to health", that is eventually mixed and complemented with neoliberal vocabulary such as "(minimal) universalism", "individual responsibility", or "efficiency and competition". In spite of the emergence of healthcare as a policy area being attached to an expanding bureaucratic apparatus, most programs and projects have remained inconsistent and fragmentary due to the composition of Turkish society and economy and the persistent struggles between different forms of governments. The findings suggest that only with the so-called Health Transformation Program (HTP) that is implemented since 2003 under the government of the Justice and Development Party (JDP), a health system has emerged that is consistently based on a distinguished mode of government. Neoliberalism, understood as the attempt to take the formal principles of a market economy and projecting them onto a general art of government, constitutes the underlying tenet of the HTP's wide net of programs, projects and regulations by which the government attempts to create, rather actively but from a distance, a health system in which all players act rational, economically and self-responsible.

Keywords: Turkey, Welfare State, Social Policy, Health Care, Governmentality, Health Transformation Program, Neoliberalism

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List of Abbreviations

ANAP	Motherland Party (Anavatan Partisi)
AKP	Justice and Development Party (Adalet ve Kalkinma Partisi)
CHP	Republican Peoples Party (Cumhuriyet Halk Partisi)
DP	Democrat Party (Demokrat Parti)
DPT	State Planning Organization (Devlet Planlama Teşkilatı)
HTP	Health Transformation Program (Sağlıkta Dönüşüm Programı)
ISI	Import Substitution Industrialization
JO	Just Order
JEO	Just Economic Order
JPO	Just Political Order
MHSA	Ministry of Health and Social Assistance
MoH	Ministry of Health
NGO	Non-Governmental Organization
NVM	National View Movement (Milli Görüş)
OECD	Organization of Economic Co-operation and Development
PBSPS	Performance Based Supplementary Payment System
PPP	Public Private Partnership
RP	Welfare Party (Refah Partisi)
SEE	State Economic Enterprise
SGK	Social Security Institution (Sosyal Güvenlik Kurumu)
SSK	Social Insurance Institution (Sosyal Sigortalar Kurumu)
TÜSIAD	Turkish Industrialists' and Businessmen's Association (Türk Sanayicileri ve İşadamlarası Derneği)
TTB	Turkish Medical Association (Türk Tabipleri Birliği)
WB	World Bank

WHO	World Health Organization

1. Introduction

In 2003, the single-party government of the Justice and Development Party (Adalet ve Kalkinma Partisi, AKP) enacted an extensive reform package termed Health Transformation Program (HTP), thereby radically restructuring the Turkish health sector. 8 years later, Enis Barış (2011), health specialist of the World Bank and consultant of the Turkish government in health issues, published an article claiming that Turkey had made it in less than a decade 'from laggard to leader', presenting a 'textbook example of successful health reforms'; universal coverage, easier access to services, higher 'customer satisfaction', higher efficiency, or improved health standards are celebrated as the outcomes of the reforms. The article, however, also sparked irate answers by doctors, claiming that the reforms had subjected the physician-patient relation to the principles of cost-effectiveness; doctors had become managers, patients had become 'points' that could increase the physician's generally low basic salary (BMJ 2011). A system had been established that not only contradicted the bases of medical ethics but would eventually lead to total commercialization of health and thus to the provision of wrong incentives and poorer services (chapter 5). These contrasting perceptions and interpretations of the reforms' outcomes do not only reflect the existence of winners and losers or the contrast between the governing and the governed, between a sort of mandatory optimism of reform designers opposed to a particular group that faces a loss of status and security. Below these conflicts, which are ingredients to all reform initiatives, lies, as this thesis will argue, an elemental reshaping of socio-political and politico-economic tenets.

Most existing approaches to welfare state research are concerned with finding variables that explain welfare states' emergences and transformations. In doing so, they make use of categories that predominantly exhibit a universal and positivist character (chapter 2). Concepts such as 'citizenship', 'class', 'state', 'market', 'nation', 'civil society' or 'social justice' are attributed an essence and inherent consistence and findings are integrated into and assessed by these categories and often interpreted in the light of overly simplified dichotomies between them. Some analyses of welfare state transformation are for instance embedded in an investigation of class struggle. Welfare states are perceived of as an achievement of the working class wrenching concessions from the capitalist ruling elites. Others might see it as an appeasing elite-strategy to avoid a collapse of the capitalist system. Some authors regard rights-based

entitlements to more than minimal social services as an indicator of social progress that should be defended; others merely interpret them as a part of temporary economic policies that must be adjusted to changing economic circumstances. Especially the development that has commonly come to be termed as 'neoliberal globalization'[1] has sparked intensive debates, heavily influenced by moral pre-assumptions with one side using a language of crisis, claiming that neo-liberalism leads to a cutting down of the welfare state and a hollowing out of 'social rights', while the other side argues that extensive welfare states have led to a financially unsustainable system and, even more critically, to dependency and moral decay.[2]

Instead of analyzing the transformation of the Turkish welfare state and health care system by drawing upon such abstractly defined categories and explaining why and under whose influence these transformations take place, this thesis aims at interpreting foremost the outcomes of the reforms. Instead of embarking on an attempt to determine how 'mature' or 'progressive' according to the above mentioned categories the Turkish health system is, the aim is to grasp the complexity of the transformation of the Turkish health system and the changes of state-society relations reflected in them.

The theoretical framework used in this dissertation predominantly draws upon Michel Foucault's (1977-79) lectures on governmentality, the genealogy of the modern state and the genealogy of the modern subject. This alternative theoretical framework shall open new perspectives for an analysis of welfare state transformation by shifting the attention to changing modes of thought, socio-political 'mindsets' and co-relative or contradicting conducts and governmental techniques and strategies. A central part of the critical approach of this thesis consists of a 'denaturalization' of a certain conduct which is often presented as a path without alternatives, forced upon reformers by practical, often economic constraints and as the unavoidable answer of reason and logic.

In order to 'denaturalize', we have to 'historicize' and 'contextualize'. It is therefore deemed necessary not to restrain our analysis to the Health Transformation Program

1 For the use of the term in this thesis see chapter 3

2 Christopher Pierson and Francis G. Castles (2006) for instance followed this either-or-logic, structuring their "Welfare State Reader" in "Perspectives on the Left" and "Responses from the Right".

as an isolated reform program reflecting the socio-political conceptions of a neo-liberal ideology in the Turkish case. In order to understand the peculiarity of the new health system, different phases of health policy in the last century will be distinguished, shedding light on temporary struggles between different political projects and programs and their eventual outcomes. How did healthcare as a policy field develop in the early Turkish Republic? How did policies change under the developmentalist paradigms of the 1960s and 1970s? And which impact did the neo-liberal turn since the 1980s have? The focus of this thesis, however, lies on the Health Transformation Program (HTP) enacted by the AKP in 2003. As this thesis will argue, the HTP was the first reform program that achieved to institutionalize on a broad scale what could be called a 'health care regime'.

Aiming at disclosing how government in its ideas and techniques in the field of healthcare has transformed, the underlying questions of the historical account will be the following: How is public health and medical care being rationalized in governmental programs? What kind of good does 'health' represent in governmental programs and projects? Why does government want to improve the health of the population/ the individual? What are the images of the population, the individual or doctors reflected in the different periods of health care in Turkey? What are the different conceptions of the state's tasks and responsibilities? And how does government attempt to achieve its aims, i.e. by which techniques, strategies, projects etc.?

First, a necessarily brief overview over some of the most influential approaches to welfare state research will be given (chapter 2) against which the dissertation's own theoretical framework shall be demarcated (chapter 3). Chapter 4 offers an overview of the emergence and transformation of public health and health care as policy fields. Different phases of health policy are defined which are embedded in broader periods of changing state-society relations and political paradigms in the Turkish Republic. Eventually, the HTP shall be discussed as the institutionalization of the neo-liberal paradigm in the health care system.

With reference to Walters and Haahr (2006) who argue that an analysis drawing upon Foucault must take language as an irreducible minimum, the empirical data of this study will be taken from scientific studies on Turkish social policies, health policies in specific, and on state-society relations. Official publications and policy papers of Turkish governments, international institutions such as the World Bank, the OECD or

the WHO provide primary material which is evaluated according to the afore-mentioned questions using the analytic 'toolkit' that will be introduced in chapter 3. To carve out the most contested issues of recent reforms, interviews have been conducted with state and World Bank officials, private doctors and the General Secretary of the Turkish Medical Association.

2. Investigating Welfare States – contemporary approaches

There is no discipline in social sciences which has not contributed to the studies of the emergence and transformation of 'the welfare state'. Embedded in broader theories of state-society relations, the welfare state has been object of inquiry for philosophy, political sciences, sociology, economics, development studies, international relations and central to the studies of political economy. It is this confusing diversity that makes a very short review of existing approaches to welfare state research a thorny undertaking which must necessarily stay fragmentary and incomplete in the framework of this thesis.

A second aspect that deserves mentioning is that health care is presented throughout this chapter implicitly as a part of welfare state research. Even though health care constitutes one of the major components of the welfare state in terms of resources consumed with regard to the importance attached to it by citizens, the literature on health policy is often "semi-detached" from broader classic welfare state literature (Moran 2000: 135).[3] In the following, we will argue in line with scholars claiming that health care composes a crucial part of social policies and welfare regimes and should be integrated into a more comprehensive, systemic analytical approach (e.g. Moran 2000; Blank/ Burau 2007; Marmor et al. 2007).

The aim of this chapter is to first introduce the attempts to define what 'the welfare state' is before critically outlining the most influential analytical approaches. We argue that in spite of the existence of an immense variety and complexity, these approaches might be grouped into two main currents, one being concerned with disclosing main

3 Especially the current of welfare state literature attempting to categorize welfare states by cross-national comparison faced some specific features of health care that seemed to elude grouping with the rest of the welfare packages. For instance, Great Britain, usually tagged as the prototype of the liberal welfare state with high degrees of commodification, exhibits a tax-financed national health system.

variables that would explain the emergence and transformation of welfare states and the other one with reducing complexity by integrating existing "welfare regimes" into cross-national typologies. Finally, it is against these approaches that an alternative theoretical framework will be demarcated in chapter 3.

2.1 Defining the Welfare State

The term 'welfare state' is of fairly recent, Western European origin. The forerunners of modern social policy are most notably to be found in Great Britain and Germany. The 'New Poor Law Act' of 1834, the 1842 Chadwick Report on the Sanitary Condition of the Labouring Population of Great Britain, the world's first health insurance program, followed by old age pensions introduced by Bismarck in 1883 and 1889 play prominent as reference points (Briggs 1961: 221). Shortly before and after World War I, a 'dense network of local and municipal services in health, housing and social care' covered much of Europe (Gough 2005: 2).

The term 'welfare state', however, was part of the Anglo-Saxon debate not before the 1940s. Rather than providing a clear cut definition, it has come to provide an epistemological battleground for different definitions and interpretations. Arguing that 'the welfare state has no precise meaning', the Austrian liberal economist Friedrich von Hayek (2000) adds that 'the phrase is sometimes used to describe any state that 'concerns' itself in any manner with problems other than those of the maintenance of law and order' (Hayek 2000, in: Pierson/ Castles 2006: 90).

Disagreeing with Hayek, other authors attempted to distinguish between 'social policy', or the 'social service state', and the 'welfare state' (Briggs 1961, Fitzpatrick 2006, Ulrich 2005). One of the most prominent definitions stems from the British historian Asa Briggs (1961) who pointed at three directions in which organized power is modifying the play of market forces in a welfare state:

"…first, by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second, by narrowing the extent of insecurity by enabling individuals and families to meet certain 'social contingencies' (for example sickness, old age and unemployment) … and third, by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services" (Briggs 1961: 228)

It is foremost the third idea of the provision of a (still state-defined) optimum instead of a minimum, that represents according to Briggs the distinguishing feature between a 'social services state' and a 'welfare state'. T.H. Marshall's seminal work on 'Citizenship and Social Class', too, considered universal provision to be a central novelty. T.H. Marshall further connected the benefits and services provided by a welfare state in the fields of healthcare, education or social insurance to the idea of 'social rights' to which every citizen is legally entitled arguing that the concept of 'social citizenship' represented a progressive completion to civil and political citizenship that emerged as legally endorsed ideas in the 18th and 19th century (T.H. Marshall [1950] in: Manza/Sauder 2009). Rather than providing a definition, Therborn points to its function, when conceptualizing the idea of the welfare state as a 'social system of human reproduction' in which the provision of social services aimed at population maintenance and growth and at an "improvement of human existence". He understands the welfare state partly as an alternative to, partly as a supplement of the economic system, the family, communities, associations etc., thus embracing the heated debates about contradictions of capitalism and the respective reconciling or consolidating function of the welfare state (Therborn 1987).

In relation to the difference between the concepts 'welfare state' and 'social policy', Esping-Andersen emphasizes that the latter is dependent on the former as the basis of welfare states dictate the contents and orientations of social policies (Esping-Andersen 1990). Accordingly, the term 'social policy' will be used in the following in relation to concrete programmes while 'welfare state' refers to the encompassing concept around which such social policies are instituted or reformed.

2.2 Influential approaches

The reasons behind the emergence and transformation of welfare states remain contested: industrialization, free trade, capitalism, modernization, socialism, the working class, civil servants, corporatism, Catholicism, war, deindustrialization, economic crises – the list of variables that have been used to explain some aspects of welfare state development is sheer endless. Early approaches foremost underlined the significance of industrialism and its social consequences and particularly the importance of economic growth as a necessary condition for the development and expansion of welfare schemes. Later academic debate predominantly moved in two broad directions: one emphasized the role of class structure and mobilization, i.e.

society-centered explanations; the other primarily focused on state-centric explanations (Pierson 2000).

Among the first group, a variety of approaches refers to the power and influence of social groups as a crucial determinant for the development and reform of social policies. They claim that institutions of the welfare state and state institutions in general are ultimately determined by broader social forces (Skocpol, in: Evans et al. 1985). The state is thus seen as a dependent variable. Pluralist accounts point to the importance of interest groups affected by the problem in question, while other groups emphasize the class basis of particular actors. The power resource theory for instance, considered by Pierson as 'the most prominent body of research on the welfare state in the 1980s', sees social policy programs in the light of the struggle between workers and employers. The expansion of social provision accordingly reflected 'the political and organizational resources of powerful unions and social democratic parties, which were able to modify market-induced outcomes in favor of their supporters' (Pierson 2000: 793).

The second group focuses on top-down processes of policy making, claiming that politics and the state 'do matter' (Skocpol 1985). Arguing that politicians and bureaucracies have the possibility of rather autonomous policy initiatives, it is claimed that different national welfare paths are defined by elite choices and political institutions (Skocpol in: Evans et al. 1985). In this state-centered perspective, the state becomes an independent variable shaping relations within society (Jessop 2002, Esping-Andersen 1990).

2.2.1 Typologies of the Welfare State

The large amount of publications on typologies of welfare states that followed Esping-Andersen's seminal work on The Three Worlds of Welfare Capitalism (1990) aimed at disclosing cross-national differences and similarities in welfare state structures (Arts/ Gelissen 2002: 138). Instead of searching for a single variable behind welfare state development, Esping-Andersen focused on the nature of different, yet interacting factors such as the nature of class mobilization; class-political coalition structures and the historical legacy of regime institutionalization. He eventually developed a three-fold classification of welfare states from a sample of advanced industrialized countries according to their degree of labour decommodification (i.e. to what extent are individuals dependent on their earnings on the labor market) and the social

stratification they produce. Different authors went on to criticize or expand the typologies to include countries of the "periphery" often characterized as "immature" welfare states. Different variables were used with the result that more and more different typologies were produced. Ian Gough, for instance, included developing countries identifying sets of welfare regimes, defining the term as the 'entire set of institutional arrangements, policies and practices affecting welfare outcomes and stratification effects in diverse social and cultural contexts' (Gough 2004: 26).

2.3 The Turkish Case: Limitations of Welfare State studies

Attempts to develop a new theory or define a new concept comprise both, descriptions of reality and constructions of reality. Once a concept is widely used, it becomes a "convention", a sort of objectively pre-existing factor in which findings have to fit (Cox 1981: 126). While social sciences are built up upon and in need of concepts and categories to structure and schematize reality, the constructivist and normative aspects of this exercise need to be taken critically into account.

In analyses of the development of the Turkish republic, state-centered explanations play prominent as 'civil society' has for most of Turkish history been weak and scattered (Keyder 1987). Metin Heper, for instance, explains many aspects of Turkish political and social history with regards to its 'strong state tradition'. This approach is also reflected in Turkish literature on welfare state research that heavily draws upon the above-mentioned current of state-centered explanations of welfare-state transformation. The examination (and thus consolidation) of dichotomies between state and society, with the state almost unhamperedly determining society's fate, play prominent.

In addition to that, the majority of scholars attempt to contribute to 'problem-solving' theories and thus display a very distinct 'concern for what is desirable or good or right' (Cox 1981, Gabardi 2001). Above mentioned categories such as 'mature welfare states', 'social citizenship', 'social rights', 'universalism', 'neo-liberalism' are used either in order to measure the progressiveness of the Turkish welfare state (how 'universal', 'socially inclusive', 'mature' etc. is the Turkish welfare state) or to embark on a language of conflict in order to underline the threats to the 'welfare state' emanating from neo-liberal policies (Keyder 2005, Buğra 2007, Günal 2008, Yeğenoğlu/ Çoşar 2011).

In the following chapter a critical theoretical framework shall be developed that shall avoid some of these 'epistemological traps' and offer a new perspective on the analysis of social policies. Instead of integrating the findings into and judging them according to these categories and instead of telling a linear story of Turkey on its way towards becoming a mature welfare state, the thesis shall be based on a detailed description of the health system in different historical periods focusing on how the field of health care is governed and on the underlying nature of state-society relations.[4]

3. The theoretical framework

The alternative theoretical framework of this thesis draws upon lectures on the 'genealogy of the modern state' that Michel Foucault gave at the Collège de France between 1977 and 1979. While Thomas Lemke regards Foucault's original account rather as a 'fragmentary sketch' than an 'elaborated theory', other scholars have taken his approach further, developing a 'tool for the critical analysis of political technologies and governmental rationalities in contemporary societies' (Lemke 2007: 3).

In the following, a brief introduction to Foucault's approach to the analysis of government will be followed by a presentation of the 'analytical toolkit' that will inform the analysis of the Transformation of the Turkish healthcare system. Foucault's relational conception of state and society will be discussed as the basis of an approach that distances itself from the mentioned antagonistic and a-historic approaches. Whereas the concept of 'governmental rationality' draws our attention to ideas, imaginations and explanations (e.g.: of a 'just society', the 'normal subject', of the 'good doctor' or of the state's 'responsibilities' in health care), the concept 'technologies of power' shall point to the various techniques, strategies, programmes, projects etc. that government applies to manage the population and steer the conduct of citizens.

Finally, Foucault's thoughts on the "governmentalization of the state" shall be outlined, in order to carve out the transformation between different, more abstractly defined modes of government, laying a focus on the specifics of the neo-liberal technology of government. This, albeit very short, outline of western European transformation from

4 It is argued here that the proposed and followed approach stands not in irreconcilable contrast with classic approaches. Instead it might draw on their information and open new perspective by rearranging them in the light of different questions.

the perspective of governmentality does not only further clarify the use of terms but may also provide a sort of counterpart against whom the distinctiveness of the Turkish case might be highlighted[5]. Concluding remarks on governmentality, the welfare state and neo-liberalism shall prepare the ground for the final analysis of the HTP.

3.1 'Government' and 'Governmentality'

"Governing people, in the broad meaning of the word, governing people is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementarity and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself." (Foucault 1993, in: Lemke 2001: 204)

The 'problem of government' constitutes one of the central subject matters of Foucault's work. In his 1978/79 lectures, Foucault alludes to a broader conception of 'government' which, in its historical use, not only refers to a government of the state and the exercise of political power but also to problems in philosophical, religious, medical or pedagogic contexts (Lemke 2000: 2). He thereby refers to an earlier sense of government, 'in evidence in sixteenth century Christian pastorals, neo-Stoicism, pedagogy and advice to the prince', encompassing 'the government of oneself, of souls and lives, of children and households' (Dean 1994: 176). Foucault suggests continuity in the analysis of these microphysical approaches to the analysis of power through to macrophysical approaches, i.e. studies of techniques and practices applied to govern "populations of subjects at a level of political sovereignty over an entire society" (Burchell et al. 1991: 3 f.).

Defining 'government' rather broadly as 'conduct', or, more precisely as la conduite de la conduite ('conduct of conduct'), Foucault eventually suggests that the term defines a vast domain between the 'minutiae of individual self-examination, self-care, and self-reflection, and the techniques and rationalities concerned with the government of the state (Dean 1994: 177).

5 Foucault's genealogy of the modern state and the modern subject is exclusively European. However, especially the avoidance of essentialist categories makes the framework applicable on a non-European context. Turkey is of particular interest here. The Ottoman Empire has long constituted "the other" in European self-conception. The Turkish Republic as its political successor, however, has never hidden its ambitions to follow the examples of the "developed West". As such, without a colonial context of enforcement, many ideas and transformations in European government have been absorbed into the Turkish reality as an act of choice. The resulting reciprocal effects, tensions and inconsistencies will be part of later chapters.

Based on the assumption that 'individuals are not merely subjects of power but play a part in its operations' (Miller/ Rose 1992), Foucault argues that the emergence of the 'modern state' and the 'modern subject' are intertwined, produced and defined by mainly two technologies: technologies of power and technologies of the self (Foucault 1989, Coveney 1998). In his studies on the organizing and changing technologies of the modern state, Foucault brings these two concepts together, arguing that the art of government is the establishment of continuity between a government by the state and discipline of the self. In this sense, 'government' is not about 'dominant sovereign power or democratic party politics'. Instead, the analysis investigates a range of practices: 'tactics, strategies, techniques, programmes, dreams and aspirations' of those authorities who attempt to shape beliefs and control of the population, subjects or citizens (Nettleton, in: Coveney 1998: 461 f.).

'Governmentality' is the term most widely used in summarizing these multiple perspectives of Foucault's thoughts on government. While Foucault (1988) himself identified the term, similar to the explanations above, as 'the contact between the technologies of domination of others and those of the self', Mitchell Dean adds that it defines a 'novel thought space across the domains of ethics and politics, of what might be called 'practices of the self' and 'practices of government', that weaves them together without a reduction of one to the other' (Dean 1994: 174).

In hinting at the etymological conjunction of governing ('gouvernor') and modes of thought ('mentalité'), Thomas Lemke furthermore stresses the 'analysis of political rationalities underpinning technologies of powers' as being central for governmentality studies (Lemke 2001). 'Governmentality' thus contains a specific form of representation, i.e. a 'discursive field in which exercising power is being 'rationalized' (delineation of concepts, provision of arguments and justifications for certain policies, e.g. for an extension of public health – 'strong nation', 'strong economy', 'human right'). In that way, government is able to offer strategies and solutions to a problem. On the other hand, this 'intellectual processing of reality' provides the ground for intervention through specific political technologies, that are 'understood to include agencies, procedures, legal forms, etc., that are intended to enable us to govern objects and subjects of a political rationality' (Lemke 2001: 191).

3.2 Concepts and 'toolkit'

3.2.1 State Theory

Particularly Marxist critics have confronted Foucault with the charge that his work lacked an elaborated theory of the state (Jessop 2007). Foucault countered these reproaches by arguing that he 'must do without a theory of the state, as one can and must forgo an indigestible meal' (Foucault [1979] 2008: 76 f). He continued, however, by claiming that the problem of state formation or the problem of bringing under state control, of 'statification' (étatisation) was at the heart of the questions he tried to address (ibid.). How to make sense of that ostensible contradiction?

Firstly, Foucault rejects the idea that the state had an 'essence' from which a certain set of practices can be deduced[6]. The state should not be conceptualized as a sovereign authority that exists external of and opposed to society, i.e. with state sovereignty on the one side and society and its actors as objects of a state legal system and state administration on the other. (Foucault [1979] 2008: 4ff). Instead, the state, just as other political and social categories like civil society, class, nation, religion, science etc. should be thought of as an effect of societal power relations at a specific moment or period in time (Foucault [1979] 2008: 77). As these power relations are understood to be in constant change, the state itself must be conceived of as a 'mobile shape', materializing and changing in its institutional structures on a political level (ibid.). The nature of the state (rather than 'the state' itself) is thus to be understood by scrutinizing the practices of multiple actors and their acting on each other.

Foucault thus regards the state as a relational ensemble and treats governmentality as a set of practices and strategies, governmental projects and modes of calculation that operate "on something called the state" (ibid.). This something is the terrain of a non-essentialized set of political relations rather than a universal, fixed, unchanging phenomenon. In this sense, while the state is pre-given as an object of governance, it also gets reconstructed as government practices change. This is what Foucault refers to as a process of 'perpetual statification' (ibid.).

6 One of the most prominent conceptions of 'the State' stems from Max Weber. According to Weber, the state is that entity which claims the (legitimate) monopoly on violence ('Monopol legitimer physischer Gewaltsamkeit') over a given territory.

3.2.2 Subject and population

Focusing on the 'multiple and divers relations between the institutionalization of a state apparatus and historical forms of subjectivization', Foucault delineates how the "modern sovereign state" and the "modern autonomous individual' co-determined each other's emergence (Lemke 2007: 2). Governmental activities always include assumptions about their targets, may it be the individual, collectivities or the whole population. Policy initiatives, party programs, but also non-political discourses reflected in media or advertisement reflect certain imaginations and rationalities that themselves serve to steer individuals. Thus, an analysis should ask the question 'how do certain programs or techniques 'imagine the subject, how does the subject imagine him or herself and how are those imaginations interacting with/ co-determining each other?" (Curtis 2002: 506)

The term population gives reference of how objects of government change. Population(s) as a concept and as a 'problem' only emerged with the creation of modern forms of government. Foremost through registration techniques and statistics, problems of the population such as epidemic diseases, employment, wealth etc became measureable and knowable. It is this 'discovery' of population, 'known through political economy and organized through apparatuses of security' that sustained the transition to the 'governmental state'. The exercise of power in that context is targeted not (only) at the single subject but at the population with the aim of increasing its overall welfare through different techniques and tactics and on the basis of 'knowledge of all the processes related to population in its larger sense: that is to say, what we now call the economy' (Foucault [1978] 1991: 99ff).

Accordingly, Foucault has shaped the terms 'biopower' or 'biopolitics' which are of particular importance in the field of public health. Population consists of human beings and their basic biological constitution. Population has a birthrate, it ages, and it has a health condition. Accordingly, population is regulated through influencing reproduction, mortality, and birthrates. The discovery of population and its laws constitutes a central step in the governmentalization of the state (Lemke 2001).

3.2.3 Governmental Rationality

As mentioned, governmentality studies are concerned with the rationality behind policies and political programs. Seeking to make political reason more intelligible, governmentality research is not meant to discover a general kind of reason underlying

all political practices but always very specific types of rationality. By paying close attention to 'language, mentality and idiom' we may discover particular expressions and perceptions of problems or governmental problematizations and the aspirations reflected in them (Walters/ Haahr 2005: 6).

Miller and Rose regard political rationalities as discernable "regularities" in political discourse which itself is to be understood as a "domain for the formulation and justification of idealized schemata for representing reality, analyzing it and rectifying it" (Miller/ Rose 1992: 7). The concept of Political rationality provides a tool for the evaluation of a specific understanding of the distribution of tasks and actions between different "authorities", such as "political, spiritual, military, pedagogical, familial" and the ideals or principles which government should be based upon – "freedom, justice, equality, mutual responsibility, citizenship, common sense, economic efficiency, prosperity, growth, fairness, rationality" etc. As such, political rationalities have a moral form (ibid.). They also contain an "epistemological character" in the sense that they reflect a specific perception and use of categories that governmental activity is targeted at, such as "society, nation, population, economy." How do governmental programs and projects understand the persons that are governed: as "members of a flock to be led, legal subjects with rights, children to be educated, a resource to be exploited, elements of a population to be managed" (ibid.)?

Where best to discern those rationalities? Miller and Rose define government as a "problematizing activity". Government defines and articulates problems as well as programs and projects to solve those problems. It is in these activities where existing policies are called into question and alternatives are being formulated where mentalities and rationalities can be best identified. The concrete analysis, meanwhile, has to be based on hermeneutic study. Language is to be regarded as an "irreducible medium" that is not "a mere reflection of an underlying 'real' world, but as a constitutive dimension of reality. Political struggles are also conflicts over meaning" (Walters/Haahr 2005: 6). Connecting discourse analysis to the history of arts and practices of government, the following analysis will, as mentioned in the introduction, predominantly refer to policy papers, official publications, legal texts, and academic publications rather than drawing upon media or popular discourses.

3.2.4 Technologies of Power

Technologies of power are 'technologies imbued with aspirations for the shaping and conduct in the hope of producing certain desired effects and averting certain undesired ones' (Rose 1999: 52). In the concept of 'governmentality', 'technology of power' is a necessary analytical correlate to the concept of 'political rationality'. As Lemke aptly states, "there are two sides to governmentality" (Lemke 2001: 191). On the one hand, the term pin-points a specific form of representation, i.e. government defines a discursive field in which power is 'rationalized'. On the other hand, it also gives ground to a 'specific form of intervention' (ibid.). This means that a political rationality is by no means neutral knowledge reflecting the governing reality. It rather constitutes the 'intellectual processing of reality' (by the activity of problematizing) which political technologies can then act upon. This is understood to include agencies, procedures, institutions, legal forms, etc., that are intended to enable us to govern the objects and subjects of a political rationality (Dean 1999). Technologies of government are thus to be understood as the collectivity of heterogeneous mechanisms and techniques through which the behavior and action of people are steered or regulated. As such these technologies define or represent the attempt to define a specific mode of government that can be put into effect for 'the state as a whole' (Miller/ Rose 1992: 13).

In this framework, 'how' questions are attached central significance. While most studies of policy processes are concerned with actors, interests, institutions and structures trying to explain why things are the way they are, governmentality studies shed light on the technologies used to govern people without pre-assuming naturalness of the conditions we find. The concept of technologies "allows us to defamiliarize the taken for granted" (Walters/ Haahr 2005: 14). In other words, while people take "their" contemporary governmental practices usually as natural, governmentality studies regard them as "exceptional, rare and historical" (ibid.).

3.3 The 'governmentalization' of the state

It is the disclosure of great historical changes within the dominant set of governmental practices on which grounds Foucault constructs his 'genealogy of the modern state'. Analyzing the development of (western) government reaching from Ancient Greece to contemporary forms of neo-liberalism, Foucault distinguished historical domains of modes of government defined and underpinned by a technology of power; from the

idea of a form of 'pastoral power' in antiquity and early Christianity over territorial states defined by the technology of sovereignty, the administrative state under the 'disciplinary technology' in the political rationality of 'raison d'état' to the governmental technology of liberalism and its fundamentally revised post-war forms of neo-liberalism (Foucault [1979] 2008: 6 ff.).

What Foucault terms as the beginning of a "governmentalization of the state", the emergence of "government as a general problem" starts roughly between the 16th and 18th century. "How to govern oneself, how to be governed, how to govern others, by whom the people will accept being governed, how to become the best possible governor" –these problems in all their complexity are located by Foucault in a time when the great territorial, administrative and colonial states replaced the structures of feudalism in the occidental sphere (Foucault 1991: 87).

While the sovereign had been ruling over a territory, using mainly law - made only by himself - imposed on the subjects to achieve stability within the territory and thus of his own reign, government started to be concerned with the right "disposition of things" to reach an increasing array of aims or finalities being convenient not only for the 'common good' but for 'each of the things being governed'– e.g. "ensuring that the greatest possible quantity of wealth is produced, that people are provided with sufficient means of subsistence, that the population is enabled to multiply" (Foucault 1991: 95). The personalized rule of the sovereign, legitimized in transcendental terms subsequently lost significance. Instead, the new rationality gained strength that the state, with all the things and people within its borders, had to be administered and in the name of the reason of state to make the state rich and strong.

Instead of imposing law on men, government introduces a 'positive form of power'. Instead of forbidding, governments wants to develop in a certain direction and thus starts to dispose things and use tactics to "arrange things in such a way that, through a certain number of means, such and such ends may be achieved" (Curtis 2002: 521). To attain its goals, the emerging administrative state used new governmental techniques and mechanisms under the dominance of the 'technology of discipline'. It undertook the function of setting incentives, reinforcements, exercise control and surveillance etc. to increase the performance of individuals that were much more than under the sovereign, part of the political construct. Through the use of knowledge and techniques such as statistics, methods of regimentation and discipline reflected in the

respective institutions such as schools, hospitals, prisons, manufactories, poor and working houses etc., the state became an omnipresent authority intervening more or less visible into the every-day life – and in every aspect– of the "subject", thereby advancing what Foucault referred to as a constant 'bringing under state control' or 'statification' (étatisation) (Rose 1999: 104; Foucault [1979] 2008: 77).

A central novelty emerging with the establishment of the art of government is the "introduction of economy into political practice", i.e. the emergence of political economy. Whereas the older meaning of "economy" signified the "wise government of the family for the common welfare" of its members, the application of "economy" at the level of an entire state, exercised towards its "inhabitants and the wealth and behaviour of each and all" becomes the very essence and main objective of modern government (Miller/Rose 2008: 11 f.). It is in the 18th century, mainly with the emergence of classical liberalist theories, that the word "economy" changes its meaning from a form of (familial) government towards a "level of reality" and "a field of intervention" (ibid.: 27ff).

In the course of the 18th century, the dominance of technologies of discipline of the administrative state was incrementally replaced by liberal technologies of government. In the center of these developments stood once more a change in the conceptualization and rationalization of the object(s) of government and their relation to the whole and the governors. The idea of an autonomous (civil) society that the state is responsible for and whose conduct is seen as a task of government gains strength. While raison d'état aimed at the state's growth in strength, wealth and power through regimentation and discipline, the upcoming liberal rationality problematized the definition of the limits of government with reference to the nature of economic and societal processes (Rose 1999: 94). This nature, conceptualized as eternal and pre-given, was to be respected and protected by government. The central question thus became how not to govern too much. And while "civil society" became a variable that challenged the disciplinary administrative state, "economy" became a central variable for the limitation of government. Freedom becomes a central idea not only with respect to the individual competing in the market with others but also and accordingly with regard to governmental activity. Government, or governmentality, thus has to aim at conducting the conduct of people in a population with all their different interests, wishes and norms without limiting their freedoms while still minimizing risks. The

assumption or 'discovery' by economists like Adam Smith that human society and its development had a quasi nature implied radical governmental conversions (Burchell et al. 1991: 15).

The abstract governmental tenet of "laissez-faire" must be seen as a consequence of the respect of that nature and the "autonomous capability of civil society to generate its own order and prosperity" (ibid.). Addressing itself to the ensemble of the population, governmentality in the framework of "active laissez-faire" policies, state intervention was supposed to "assure the security of those natural phenomena, economic processes and the intrinsic processes of population" (ibid. 20). Liberty thus becomes a central part of the governmental rationality itself.

3.3.1 From Liberalism to Neo-liberalism

The term "neo-liberalism" indicates the emergence of new forms of political-economic governance which are akin to the older theories and practices of classical liberalism in the 18th and 19th century yet original and distinct at the same time (Larner 2000: 5). Jane Jenson used the term neo-liberalism as standing for "post-welfare state citizenship regimes" in general and many more argue that neo-liberalism comes with a "retreat of the state", or a "domination of the market" (Larner 2000, Lemke 2000: 10). A governmentality approach, however, sees neo-liberalism as a governmental project itself and furthermore both as a political discourse 'about the nature of rule and a set of practices that facilitate the governing of individuals from a distance' (Larner 2000).

Foucault argues that there is no coherent politico-economic theory of neo-liberalism. He refers to different schools of political economic thought, most prominent the US Chicago School and the West German Ordo-Liberals, that represented the shift towards a new design of social relations and basic assumptions which are fundamentally different from liberalism. In the classical liberalism of Adam Smith in the 18th century, the central problem was "how to cut out or contrive a free space of the market within an already given political society" (Foucault [1979] 2008: 131). The problem of neo-liberalism, meanwhile, is "… how the overall exercise of political power can be modeled on the principles of a market economy" (ibid.). Accordingly, the aim is not to free an empty space, but to take the "formal principles of a market economy and referring and relating them to, of projecting them on to a general art of government" (ibid.).

Ordo-liberals and other neo-liberal schools rejected the idea of a "nature" of the market and the according idea of a natural, i.e. primal homo oeconomicus such as suggested by Adam Smith. The market is by no means to be seen as a "natural economic reality" that governmental action must always respect (Lemke 2001: 195). Neither was competition conceptualized and presented furthermore as the natural "source and foundation of society" that had to be allowed by laissez-faire policies to rise as it is (Foucault [1979] 2008: 132). As opposed to the idea of laissez-faire it was rather deemed necessary to create through constant and pervasive political intervention an environment which assures a functioning of market mechanisms in the centre of which stood free competition. Neo-liberalism therefore has to be identified with "permanent vigilance, activity, and intervention" of government (ibid.).

The relation between state and economy was conceived of as a condition of mutual dependency and complex intertwining with one conditioning the other. The ordo-liberals thus epistemologically "replace the conception of the economy as a domain of autonomous rules and laws by a concept of economic order as an object of social intervention and political regulation" (ibid: 196). Within the framework of the ordo-liberal idea of the so-called "social market economy" (Soziale Marktwirtschaft), the state was no longer to be defined in terms of any historical mission. Collective wealth was thought to produce a social consensus on the state and the state's task was accordingly to secure its own legitimization by ensuring (or enabling) economic growth. The sole aim of state interventions and policies is the constant creation of a pure competition market which, in turn, should regulate the whole society. The state is legitimized by its task of safeguarding the appropriate framework conditions for a functioning of the competition economy. It is thus one of the main assumptions of neo-liberalism that the (perfect) economic competition market needs a state produced regulating framework (Donzelot 2008: 123 ff.).

Neo-liberalism, however – and crucial for our purpose -, redefines not only the relation in a theoretical triangle of state-market-society, it also composes a new idea of the "subject". The model of a modern individual is based on the idea of an "enterprising individual" or the "actively responsible self" (Gabardi 2001: 561, Miller/ Rose 2008). The "good citizen" or the "normal citizen" is the homo oeconomicus that calculates in every sphere of his social life. Yet, from a theoretical point of view, neo-liberalism sees

this economically thinking individual not as the natural being but an artificially created and constantly to be created, behaviouristically manipulated being (Lemke 2001: 200).

3.4 Governmentality, neo-liberalism, welfare and healthcare

What does this perspective of changing technologies of power and changes in 'stateness' mean for our understanding of the welfare state? As mentioned before, the welfare state is presented, often implicitly, as a novel, different or modern form of state, representing social progress and the possibility of a life in dignity for all. As Foucault describes the state as 'nothing more than the mobile effect of a regime of multiple governmentalities', the same accounts for the political materialization of those characteristics usually attributed to the welfare state (Jessop 2007: 6). Industrialization, urbanization and its social consequences, the political organization of workers, the experiences of sever crises of a 'laissez-faire' type of liberalism, the trauma of two World Wars and a new politico-economic tenet of demand-side management crystallized in a historically new and by no means merely political regime. The welfare state should thus not be understood as some novel or even normal form of the modern state but rather as a different mode of 'government of the economic, social and personal lives of citizens' (Miller/ Rose 1992: 21). The welfare state, or 'Welfarism', as Miller and Rose state, reflects a certain political rationality rooted in a particular conception of the nature of society and its inhabitants (ibid.).

By the same token, neo-liberalism cannot be understood by simply juxtaposing an interventionist welfare state to a neo-liberal non-interventionist state but must similarly be seen as a complex re-organization of political rationalities and their alignment with contemporary technologies of government. The emergence of these new rationalities and their techniques does not mark a replacement but constitutes a long-term struggle between different political projects and programs which might finally institutionalize in a dominant neo-liberal regime. O'Malley, for instance, argues that the history of techniques in fields such as unemployment policy or health management is not to be understood as the 'gradual encroachment of a more efficient technology of power, but the uneven, negotiated and partial implementation of a political program and the consequent (equally partial) installation of the appropriate social techniques' (O' Malley, in: Barry et al. 1996: 192).

Nevertheless, neo-liberalism breaks with welfarism in several ways, on the level of moralities, explanations, vocabularies etc. Characteristical is for instance the reconsideration of risk and responsibility based on those different moral assumptions. Welfarism as a set of regulations connected to and structured by the wish to encourage national growth and well-being through the promotion of social responsibility, solidarity, and the 'mutuality of risk' is criticized by adherents of neo-liberalism as cultivating the perception that the state has to provide for the individual. The welfare state thus has a morally damaging effect upon citizens as it evokes a 'culture of dependency based on expectations that government will do what in reality only individuals can' (Miller/ Rose 1992: 27 ff). Within the 'strategic vision of neo-liberalism', the welfare state is 'sapping the energy and enterprise of individuals' (Barry et al. 1996: 194). The 'free market' in turn would reinstate the morally-responsible individual. Whereas collectivized or socialized risk-management techniques cause social dependency, privatized risk mechanisms, i.e. privatized actuarialism, would make individuals calculate rationally and take responsibility for their own lives while bearing the (known) consequences of risks included in their decisions. Further responsibilized by state promoted progress in different fields such as weight-loss and fitness, anti-smoking campaigns etc, the individual is incorporated in the managing of his/her body and 'risk-management becomes an everyday practice of the self` (Barry et al. 1996: 199).

Accordingly, the conception of 'risk' changes from Keynesian welfarism to new forms of neo-liberalism. Risks like unemployment or poverty were thought mainly to evolve from failures of market capitalism in the former. As such, unemployment or poor health is attributed to social inequalities (living conditions, diet, education etc.) and interventions are accordingly targeted at these framework conditions and not the individual in the first place. Neo-liberal approaches to government, meanwhile, conceptualize risk as a constitutive, driving force for societal development; 'a source or condition of opportunity, an avenue for enterprise and the creation of wealth'. Risk is a driver for innovation, without risk, individuals would lose their will to strive for betterment and instead fall into dependency (Larner 2000: 246). With the state providing all the necessary basics of a successful life, it is the responsibility of the individual to seize the opportunities and his own fault, if he/she does not.

While certainly not leaving all risks to the subject, the state has to find to dispose 'things in the right way' to create the appropriate conditions for the rational and responsible individual to unfold. Together with experts (such as doctors), the state's task becomes the generation of information and its dispersal to the citizen who then can (and has to) decide on his/her own (Barry et al. 1996: 206 ff.). The consumer of health services transforms from a passive patient, gratefully benefitting of the knowledge of medicine to an entrepreneurial individual responsible of himself and aware of his options and rights, an autonomous agent who makes decisions, pursues his/her preferences and 'seeks to maximize the quality of his/her life' (Miller/ Rose 1992: 34).

Yet, exceeding the often criticized self-responsibilization of patients ('with all the ''victim-blaming' consequences this implies'), Osborne states that

"The principle of responsibilisation works like a moving force throughout the whole system, giving it coherence as its principle of functioning. So managers are to be responsible for managing hospitals as businesses, general practitioners are to be responsible for managing and budgeting their practices, and patients and, of course, potential patients are to be entrepreneurs of their own health. Because health is not an absolute value, neo-liberalism attempts to construct values according to a kind of immanent logic – it involves a kind of boot-strapping of surrogate health-values; targets are set, market-exchanges take place, performance is monitored, success and failure rates are measured, new targets are set, further market-exchanges take place." (Osborne 1997: 186)

4. The Turkish health care system

The following chapter shall provide an overview of the transformations in the Turkish health care system. Special attention will be paid to changes in the dominant political rationality, to altering objectives and objects of government and the techniques applied to govern the field of healthcare. This will be embedded in a discussion of broader transformation in state-society relations.

4.1 Health Care under the Sultans – a remark

The late Ottoman Empire's social policy encompassed three rationales: First, the theme of the divine and benevolent Sultan who generously distributes certain services to his people in a more or less arbitrary manner; second, the incremental and rather inert

construction of a western-type administrative apparatus to centralize and rationalize governmental action on the population and third, the enduring importance of the theme of partly private, partly officially organized charity, philanthropy and poor relief.

Nadir Özbek highlights the importance of social policies for the sultan's aspiration to secure and increase the legitimacy of his rule over a multi-ethnic empire that was rapidly falling apart. Social policies were closely connected to a redesigning of the sultan's image. The construction of a poorhouse in Istanbul (Istanbul Darülaceze Müessesesi) or the Imperial Hospital for Children (Hamidiye Etfal Hastane-I Alisi) might be seen as indicators of how sultan Abdülhamid II 'used the field of charity and relief to highlight the person of the ruler as the protector of his people' and a 'caring father' (Özbek 1999: 2). Initiatives in the field of health did ultimately not refer to the people but to the Sultan's own rule and legitimacy. It was not the health of his subjects which was important to him but their loyalty in exchange for his generosity.

Simultaneously, first attempts to rationalize and centralize interventions in the field of health care and other social policies emerged targeting the growth and strengthening of the people. The general administrative capacity began to extend with the Tanzimat (reorganization), a period of extensive reforms in the late Ottoman Empire aiming at modernizing state-structures and institutions according to Western models, aspiring to hold together the collapsing empire. Even though the only laws passed under the Ottoman Empire regarding health care concerned emergency services during wartime, general state activity and capacity to regulate an expanding social sphere broadened (Savas et al. 2002: 16).

Thirdly, charity, philanthropy and poor relief communicated particularly by the language of Islamic values were deemed to support those who were deprived of all security. Apart from individual almsgiving (sadaka and zekât), all forms of help for the poor and needy had long been carried by charitable foundations (vakıflar) which have continued to assume a central role in the provision of social services in the Turkish Republic, complementing or even replacing formalized state schemes. Social policies and health was thus simultaneously a stage of exposure, a field of political intervention on the population and a religious-moral question of solidarity.

Modernization theory and teleological approaches typical for mid 20th century social sciences have described the history of relief principally as a phase in the linear development towards modern social policy. Poor laws are conceived of as a

progression from kinship, welfare as a progression from charity, state provision as a progression from private giving, with the zenith being 'the modern welfare state, with all its institutions and policies' (Jones [1996] in Özbek 1999: 4). Rejecting this positivistic perspective, different phases in the organization of social and health policies shall be discussed not as a progressive development but as a context-embedded and unique historical manifestation.[7]

4.2 "The strong nation" - Healthcare in the early Republic

With the foundation of the Turkish Republic in 1923, the sovereign rule of the sultan came to an abrupt end. The fast construction of an administrative state, however, did not put an end to sovereign forms of rule. The distribution of favors and privileges to certain groups in return for loyalty continued in combination with repressive and authoritative techniques aiming to secure the own rule (Heper 2000: 69).[8] The idea of constructing a homogeneous Turkish nation state, fit to survive in a war and crisis-ridden international surrounding made up the core of the project that was headed by President Mustafa Kemal Atatürk and former reformist military elite circles. Subsequently, reforms were implemented to purge the Turkish language of Arabic influences, the new state was declared secular and laic and the sultanate as well as the caliphate were abolished; even Western clothing style was legally dictated (Kuru 2009: 210 ff.). The multi-ethnic Ottoman Empire's successor was not a homogeneous Turkish nation state; but it was to be made one. In the framework of this 'civilizing mission', a wide array of techniques was targeted at reshaping the mindset and acting of the "Turkish people" who were to think and act secular and with a strong national consciousness (Göle 2010: 253).

Public health policies have to be assessed with a view to this rather disorganized setting that the 'project managers' set out to re-organize in the framework of their idea of a Turkish nation state. Public Health as a newly developing policy field was fundamentally influenced by the vision of a 'strong nation' made of 'robust men' and 'healthy mothers' giving birth to a great amount of healthy children (Akin, in: Günal

7 As such, the following will be in line with more recent literature in social science pointing to the existence of 'multiple modernities'. E.g.: Eisenstadt (1999).

8 The early Republican period was, in spite of bureaucratization, characterized by a personalized and leader-centered political culture which has left traces until today. Heper (2000) tells the anecdote of Süleyman Demirel, head of the Justice Party and President of the Turkish Republic (1993-2000), holding 'like a true sultan… a weekly audience with his subjects' declaring that 'those who are in need of anything can call on me' (Demirel [1993] in: Heper 2000: 69)

2008: 168). Health policies were thus by no means motivated by a concern for the individual citizen. Instead, the individual and his/her health were subordinated to the idea of the nation state. The nation, its strength and its survival composed the purpose of government as well as its legitimization. As such, health policies still referred to the consolidation of rule. Yet, unlike the sultan, government now regarded the development and strength of "the things" within the nation state as crucial for the strength of 'the whole'.

As World War I and the following war of independence had left Turkey with a depleted population suffering under severe epidemics and contagious diseases such as malaria, tuberculosis or syphilis, a public health infrastructure was to be established primarily to control the spread of infectious diseases and to improve the 'strength of the nation' (Aydın, in: Ağartan 2008: 138). The Ministry of Health and Social Assistance (MHSA), established in 1920, drew up a reorganization of services to provide preventive care to all citizens, eradicate infectious diseases and particularly to reduce overall death rates (Günal 2008: 147). Key bureaucrats, such as Dr. Refik Saydam, Minister of Health from 1920 until 1937, endeavored to develop a public health infrastructure with a division of labor between the central government and local bodies; the state was to provide preventive care while the organization of curative services were left to the hands of local governments (Savas et al. 2002: 17).

In its first official program issued in 1925, the MHSA determined its priorities as follows: to expand the state health organization; to train doctors, health officers, and midwives; to establish model hospitals (numune hastaneleri), maternal and child care hospitals; to combat heavy diseases like malaria, tuberculosis, trachoma, syphilis, and rabies; to prepare health legislation; to bring health and social assistance organization to the villages; and to establish a school of public health and institutes of public health (Günal 2008: 149 ff). A web of laws and regulations was furthermore implemented to organize the field of health care. The Village Law, the Municipality Law, the Law of Public Health, the Law on the Application of Medicine and Its Branches, the Law of Pharmacy and Medical Products, the Law on the Organization and Personnel of the Ministry of Health and Social Assistance and other laws such as on the pharmaceuticals, bacteriology, private hospitals etc. These laws and regulations aimed at defining governmental and municipal responsibilities, standards in training, education and medical practice, in hygiene, nutrition, water, sewer systems etc (ibid.:

152). With the Law of Public Health (Umumi Hıfzıssıhha Kanunu) in 1930, the 'protection of the health of the nation' (not the individual) was announced to be a state responsibility. In a public environment in which the individual did not expect the state to provide for social security of any kind, government, under the image of a caring father ('protection') started to manage the development of population 'for (and through) the nation state' (Tuncer 2011).

The emergence of biopolitics and population as a target of governmental activities in the field of public health was one of the most important novelties of the early Republican period. The basis of a strong nation-state was believed to be a 'healthy, fit and numerous population', constituting a 'military power' in times of war and an 'economic power' in times of peace (Shorter 2000). In 1934, the Parliamentary Committee on Population of the Republican Party wrote: 'although the importance of the population on economic grounds is fully recognized today in Turkey, the goal of promoting the strength to defend our vast land is the most important.' The party committee then declared the aim of doubling the population as soon as possible to achieve a high military capacity (Shorter 2000: 116). In the framework of these pro-natalist policies, "promoting birth, preventing high infant mortality rates, and securing better conditions for infant and child survival were the points on which all the doctors, intellectuals, politicians and social activists agreed in the debates on the scientific management of the population" (Günal 2008: 161, emphasis added).

The convergence of government towards its objects, its concern with constructing and intensifying the management of the state, understood in the field of healthcare literally as an organic entity, was meant to be achieved through a central administrative apparatus using techniques of discipline and sovereignty alike; e.g. laws and regulations on drugs and services, education, hygienic control or the prohibition of individual family planning. The highly ambitious enterprise was to bring government into the lives of each and everybody and to establish continuity between the development of the nation state and the government of oneself (e.g.: giving birth as a contribution to the nation).

4.3 The emergence of a 'dual welfare system'

After WW II, Western industrialized countries strived to find politico-economic answers to the failures of laissez-faire liberalism of the late 19th early 20th century and ways to prevent extreme deviation, which was regarded as a central variable to explain the

possibility of the horrors of two World Wars. The new projects that were not aimed at but provided the ground for the emergence of modern 'welfare states' were based on the assumptions that state intervention particularly in the form of demand-side management was not only needed to compensate for market failures but also for the provision of the right conditions for capital accumulation, eventually resulting in a prosperous and stable system (Jessop 2002: 61 ff). [9]

As a country located at the 'periphery' of the industrialized West, the Republic of Turkey had followed a different transition. Its economy was dominated by agricultural production; neither industrialization nor urbanization was advanced and liberalism of any kind had never been dominating political government as a coherent idea. Nevertheless, the Turkish Republic continued to follow debates in the 'developed West' closely, attempting to transfer scores of aspects of it into the Turkish reality. In many policy proposals and programs, Keynesian policy-priorities and western state structures were declared as reference points (Ağartan 2008: 141). The influence of new international institutions such as the World Health Organization, policy consultancy by international experts and the entry of Turkish experts educated abroad into the bureaucratic apparatus further promoted the transfer of knowledge and experience.

With the general elections of 1950 and the victory of the Democratic Party (Demokrat Parti, DP), Turkey witnessed for the first time a change of governments induced by elections. Successfully mobilizing especially the rural electorate under topics of rural development and democratic shortcomings under the CHP, DP Prime Minister Adnan Menderes established in the course of his 10-year rule a peculiar mixture of 'free market' policies and political culture characterized by the rules of 'rent-seeking and distribution of favors to friendly businessmen' (Buğra 1994: 124). This system of clientelism and the mix of different modes of government was sustainable for a certain period amongst others due to massive financial support under the umbrella of the Marshall Plan (Zürcher 1998: 222 ff.).

9 While John Maynard Keynes and William Henry Beveridge are frequently named as 'fathers' of modern welfare states, their politico-economic conceptions should not be seen as promoting state-provision of welfare services in the first place but as re-organizing economic policies, i.e. the state's role in the market, in order to stabilize economically gained welfare in nation states (see e.g. Marcuzzo (2006)

The 'First Ten-Year National Health Plan' (Milli Sağlık Planı) issued by the then still governing CHP in 1946 signified both, a new interest in the governmental technique of planning and the acknowledgement of the manifold problems in health provision and financing. Even though the plan was not transferred into legal texts, its content reflected and influenced further policies (Akdağ/ MoH 2009: 14 f.). In terms of financing, the plan foresaw an adoption of the social insurance principle that had been 'tested successfully' in the 'developed West' (Ağartan 2008: 145). Alternative proposals were discussed and remained on the table. Especially another "western model", a tax-financed national institution as existent in Great Britain was attractive as the economic basis for a premium-based insurance was not existing due to a agriculture dominated labor market and unpaid work in family businesses.

In 1946, however, a first social security organization was established that was to cover exclusively formal-sector workers against all health-related issues (Laborers' Insurance Institution, later: Social Insurance Institution 'Sosyal Sigortalar Kurumu' SSK). Different from most west European insurance institutions that buy services from public and/or private providers, the SSK built its own hospitals and dispensaries providing at least in theory services only to its own members. The priviledged group of insured was constituted almost solely of urban industrial workers employed at enterprises subject to labor law. As a second social security institution, the Retirement Chest (Emekli Sandığı), established in 1949, protected civil servants and their dependents against risks of old age and sickness (Ağartan 2008: 140 ff.). In 1950, the two funds provided coverage for only four percent of the whole population. The large majority, comprising workers not covered by the SSK, the poor and unemployed in urban areas as well as the rural population, in total comprising about 80% of the population, were not covered by any social insurance scheme. This emergence and institutionalization of priviledged groups lay ground for what Seeking calls an 'inegalitarian corporatist welfare regime' (Seekings 2005, see chapter 4.6).

The health plan furthermore included a restructuring of health services to provide 'satisfactory services to rural Turkey' as the 'source of the strength of the nation', feeding 'the whole country with its agricultural products' and contributing 'to the expansion of population by high rates of child bearing' (National Health Plan [1946] in: Ağartan 2008: 146).

While a growing industrial sector and large population movements to the cities in the DP era implicated social consequences such as the partial separation of families and problems of unemployment, social policies were hardly part of the political discourse. Discourses of social justice, prominent in Menderes' election campaigns mainly referred to political and economic facets such as the economic development of rural areas and their being provided with special favors by the central government. Accordingly, the DP partially assumed that the newly established social insurance funds would take effect through a growing formal labor market and the increasing ratio of premium paying workers. Simultaneously, the government under Prime Minister Adnan Menderes not only relied on informal networks such as the extended family and the foundations but allowed for the emergence of new ones such as the shantytowns (gecekondu). Urban migrants – tolerated by the government– appropriated public land in the periphery of cities to settle with larger groups from the villages of origin thus transporting their own informal networks of social security. Active social policies were only targeted at the countryside as 'in our country, social justice, rather than being a matter of concern for the problems of the proletariat, is a question pertaining to the problems of the farmer and the countryside' (Adnan Menderes, in: Buğra 2007:42).

In terms of healthcare policies, the DP stood for continuation. Subsequent party programs emphasized the lack of health services in villages as a major problem and facilities were constructed without designing general approaches of how the overall system should be organized. Pro-natalist policies were perpetuated and the need to bring health services to peasants was highlighted as a condition to increase the population (Zürcher 1998: 197). It is especially the more than two-fold increase in the number of hospitals and a nearly thirty-fold increase in the number of health centers that distinguishes the DP period from all other periods (Günal 2008: 179). The DP period is furthermore characterized by a rising demand for health care, a certain degree of commercialization of medicine with a simultaneous increase in state involvement in curative services. Uninsured people and people who could not afford the treatment they needed were to be covered by a special administrative budget. A health bank was established from which health expenditure should be financed (Akdağ/MoH 2009: 17).

4.4 Health care and developmentalism (1960-1980)

The 1960 coup d'état of the Turkish military, self-declared and to a certain extent accepted 'protector of state interests, order and stability', and the following re-organization of political rationalities and modes of government have to be understood as a reaction to the DP's populist, clientelistic and authoritative policies which had, in the eyes of the coup leaders and the CHP, resulted in a setback of state development in the name of personal interest (Heper/ Keyman 1998: 264, emphasis added).

While integrative measures on all policy fields with the aim to achieve the highest possible degree of national homogeneity had constituted the linchpin of government in the early Republican era and a 'resort' to sovereign, particularistic modes of governing had determined the DP-era, socio-economic development of the state as a whole, the "catching up with the West", were to determine the new policies. The main reason of the state and likewise its legitimization was seen as promoting 'national development' and forces within the state were to be incorporated and bundled towards this aim.

The new rationality materialized in the 1961 constitution. Besides re-defining and establishing new state-institutions, the constitution had a "strong programmatic character" and formulated the government's foremost economic goals to be achieved through planning. "Planning instead of patronage, industrial growth instead of populism, and an urban, polished universalism instead of rural parochialism were emphasized" (ibid.). Import Substitution Industrialization (ISI) was chosen as the politico-economic instrument to strengthen the state by creating a strong national industry, stabilize it by a more independent domestic market and to bring Turkey to the developmental level of Western countries (Tuncer 2011: 128). The Republic's struggles between the opposing choices of trying to keep its relatively independent course of industrial development on the one hand and further integration into the global economy through liberalization on the other hand was to continue throughout the 1960s and '70s (Aydın 2005: 28).One of the new institutions which most clearly reflected the will to methodically and rationally promote Turkey's socio-economic development was the State Planning Organization (Devlet Planlama Teşkilatı, DPT) founded in 1960. The state used this institution as an instrument to reorganize its own role within economic processes. The usage of limited resources as well as the coordination of state-investments was to be organized according to rational criteria to overcome the dissipative distribution serving particular interests. Five year

development plans, Import Substitution Industrialization, an increasing number of state-owned enterprises were central aspects of a new form of governing attempting to overcome the remainders of sovereign forms of power that the DP had, in spite of its overall liberal outlook, extensively drawn upon.[10]

In the years between 1960 and 1980, the mix of different mechanisms of welfare provision was consolidated. Industrialization and rapid urbanization were accompanied by an increase of informal working agreements. Most of the domestic migrants found work in small urban industries, services or petty commerce without social security regulations. Similar to Adnan Menderes, the aspiration of policy makers was that industrialization and economic growth would lead to the integration of workers into the formal labor market and thus to the replacement of informal mechanisms of welfare provision by a social insurance system (Keyder 2005). The dual welfare structure of different formal insurance schemes and informal mechanism persisted and new actors such as the unions emerged to "defend the status-based insurance system against any reform initiative" to preserve "their privileges" (Ağartan 2008: 172).

4.4.1 The Law on Socialization of Health Care

The new constitution of 1961 promised "social and economic rights, with provisions both for the right of the State to plan economic development so as to achieve social justice, and the right of the individual to the ownership and inheritance of property, and the freedom of work and enterprise" (Ahmad 1993: 129).

This relatively new concern for the individual and his/ her social rights vis-à-vis the state signified an at least theoretical rearrangement of state-society relations and was reflected in new efforts towards the state provision of health care to the whole population. The Law on Socialization of Health Care (or: Socialization of Health Services Delivery Act) aimed at reorganizing the Turkish health care system with regards to both financing and provision. The main focus of the Act was to 'enable the entire population to benefit from health services along a hierarchical referral chain almost free of charge at the point of contact', thereby creating an 'egalitarian health system' financed mainly through taxation with some user charges (Yasar 2011: 111).

10 The influence of personalized rule and patron-client relationship persisted in Turkish politics. With the election victory of the Justice Party (JP, Adalet Partisi) under Süleyman Demirel, clientelism, populism and a logic of the "exercise of the 'national will' unhindered by the state elite" returned to Turkish politics (Heper and Keyman 1998).

The Act envisaged the establishment of an extensive primary care system to provide basic curative and preventive care to the entire population, thereby taking pressure off the overburdened institutions delivering secondary and tertiary care. A further centralization and bundling of capacities was to be achieved by transferring all hospitals to the MoHSA decreasing the negative impact of overlapping responsibilities. Finally, all physicians working in state hospitals were to be made full-time state employees. While these plans clearly comprise components of a tax-financed National Health System (NHS), the creation of a single payer system was not explicitly intended and the existence of different insurance schemes was allowed to continue (Ağartan 2008: 174).

The new rhetoric that was adopted especially by the military that saw itself as the reformist force in the country implied a new extension of the state's responsibility in the field of social security and explicitly of health care. Cemal Gürsel, head of the National Unity Committee told his audience on the 16th National Medical Congress 1960 that "justice, education and health were the three pillars on which society was build" and that "doctors should work in every corner of the country altruistically, like judges and teachers" (Günal 2008: 238). A live in luxury in the best places of Turkey "with a shop owner mentality" would meanwhile contradict the "honored position of the doctor within the community" (ibid.). By drawing physicians into state contracts and determine their conditions of working, options to shape their self-conception increased. Doctors were to be made part of the mission to develop the country. Minister of Health and Social Security Ragıp Üner underlined on the same congress that the main aim of the new law was to bring health to the whole country to "make people live a socially just life in accordance with the Universal Declaration of Human Rights" (ibid.). This preoccupation with 'developing', integrating and 'winning the hearts of the people' in the countryside was framed in a discourse that had a terminology of social justice at its core (Nusret Fişek, Minister of Health [1962] in: Ağartan 2008: 176). Kurds, too, portrayed by the military as ‚backwards' people, would be taught the basics of hygiene by the 'enlightened' doctors (Günal 2008: 225).

Meanwhile, the architects of the development plans in the SPO and of the reform proposals in the MOHSA were technically more concerned with economic development. "Health and size of the population was deemed important by the planners in terms of

its influence on economic development while they also highlighted the positive implications of economic development on Turkish citizens' health" (ibid. 180).

A decisive change in the 1960s was the change from pro- to anti-natalist policies. The aim of unlimited population growth to create a strong nation was replaced by a logic of population control, deemed necessary with regards to economic development and employment structures (Akdağ/ MoH 2009: 17). Further plans were made on the implementation of a General Health Insurance scheme (GHI) such as presented in the second Five Year Development Plan. However, the drafts were either rejected by the Turkish Grand National Assembly (1971) or not even negotiated (1974) (ibid.). Furthermore, the Law on the Principles of Health Personnel's Full Time Working was adopted in 1978. It prohibited those physicians working for the public sector to open private practices yet it was discarded with the next coup in 1980 and a decisive turn in governmental rationalities and techniques connected to the neoliberal opening of the Turkish economy under Prime Minister Turgut Özal.

4.5 Health care and the emergence of neo-liberalism (1980 – 2000)

When the military under General Kenan Evren took over control once more in 1980, the health insurance system was patchy and unequal and the delivery of services faced severe problems. The attempts to expand coverage which had found their most ambitious expression with the Law on the Socialization of Health Care had largely failed, not least due to the lacking administrative capacity and the frequent re-emergence of clientelistic practices which further contributed to the existence of privileged groups and the existence of very diverse relations between different societal groups and the state. By 1980, only 38.4 % of the population was covered by formal health insurance and within those covered, premiums as well as services were highly dissimilar (OECD 2006). University hospitals were associated with high technology and well educated stuff, MoH and SSK hospitals were regarded as providing poorer quality. The Retirement Fund for civil servants was spending almost three times as much per enrollee as the SSK and twice as much as Bag-Kur (Ağartan 2008: 203). The developmentalist strategy (or hope) of inducing an increase in premium payers through fostering industrial development had failed. While urbanization had speeded up rapidly in the 1970s and was even more so in the 1980s and 90s the understaffed primary care health centers were unable to meet the rising demand for services. People resorted directly to secondary care facilities which in turn set the informal

mechanism of free treatment for the poor under pressure. Hospital administrators started to reject those who were uninsured or not able to afford the out-of-pocket-payments (WorldBank 1990).

It was in this situation that Turgut Özal, founder and president of the new Motherland Party (ANAP, Anavatan Partisi) and Turkish Prime Minister (1983-1989) began the neo-liberal restructuring of the Turkish Republic (Öniş/ Şenses 2005: 272). Turkey thus became one of the first countries of the 'periphery' to take up the ideas of neo-liberalism that had gained political power under US President Ronald Reagan and UK Prime Minister Margaret Thatcher. After years of ISI-dominated policies, the opening of domestic markets for different forms of foreign investment, a government that 'retreats' to monitoring, regulating and "steering from a distance" while refraining from direct interventions such as price policies or Keynesian demand management became the new political guidelines (Yeğenoğlu/ Coşar 2009). Privatization and competition were promoted as remedies for the inefficiency and indebtedness of the state apparatus. The role of the state as a provider of services was to be limited (Günal 2008: 391). Parallel to an economic liberalization, organized labor was stripped of some of the rights granted to it by the 1961 constitution, wages decreased and public social expenditure was reduced. This paradigmatic change once more included a radical change of rationalities and subjectifications. The Turkish nation should understand itself as a society of entrepreneurs, fit enough to enter global competition. In his explanations on his "new vision" (yeni görüş), Turgut Özal underlined that the aim and the basis of social (societal?) development was the material and ideational advancement of the single members of the nation. – not the development of the state (Tuncer 2011: 144 ff).

Health policy was strongly affected by the rearrangement of the obligations of the government in health services. The new constitution of 1982, in many aspects a reversal of the more liberal 1961 constitution[11], proclaimed that 'everyone has the right to live in a healthy, balanced environment…The state shall regulate central planning and functioning of the health services…by utilizing and supervising the health

11 The constitution concentrated power in the hands of the executive, increased the power of the president and the National Security Council. It limited freedom of the press, freedom of trade unions and their rights to strike and not least the rights of the individual. It is an interesting and self-contradicting aspect of the neoliberal transformation in Turkey that liberalizing reforms were implemented as a rather authoritarian project and that, other than neoliberal projects in Western democracies, the freedom of the individual, even though proclaimed in Özal's vision, was first and foremost promoted in the economic sphere (e.g.: Zürcher 1998: 281).

and social assistance institutions, in both the public and private sectors…' (Yasar 2011: 112).

First policy changes in favor of privatization were already implemented at the beginning of the 1980s. Private health investments were subsidized; physicians working at public health facilities were given the permission to open private offices and patients were demanded to make co-payments for some drugs. In the second half of the 1980s privatization policies speeded up. The Fifth Five Year Development Plan (1985-1989), being the first development plan that called for a smaller state sector, included the following stages: (i) public facilities should operate like business enterprises for increased efficiency; (ii) private enterprises and hospitals should be subsidized; (iii) prices of services provided by the private health sector will be unregulated; (iv) contracts would be made for private physicians; (v) both public and insurance organizations should no longer provide health services; (vi) a GHI system shall be introduced (SPO 1984).

Some aspects of the plan were quickly translated into laws, yet other aspects met fierce resistance by those groups who had been privileged by the existing system. Neoliberal reform initiatives gained strength in the late 1980s and 1990s as particularly the World Bank increased its involvement as a global policy actor in the field of health care. The Turkish Undersecretariat for the Treasury signed a credit agreement with the WB and in 1989 the first health project for the development of primary health care in Turkey was drafted and implemented in cooperation with the MoH and a health project unit was founded within the MoH in 1994 to carry out the joint projects. The SPO as well as the WHO contributed to the debates with two comprehensive studies and finally, in 1993, with the 'national health policy' (NHP) a central document was prepared that should guide the way to reform. The targets were among others the establishment of a decentralized health management system, a family medicine scheme for primary health services, an autonomous secondary and tertiary health service system, a 'rational policy for human resources and payment on the basis of performance, competition among providers and a General Health Insurance system (MoH 1993). Foremost because of the unstable political environment and the changing governments and coalitions, however, the only aspect of the reform that could be implemented was the extension of entitlements to services to the poor.

The introduction of the Green Card scheme in 1993 must be regarded both as a reflection of the increasing concern with targeting support mechanisms and state interventions to the very poorest of society and with creating a GHI scheme that provides the whole population with a minimum package of health services (Kisa/ Younis 2006). The health care entitlements are issued as 'Green Cards' to Turkish Citizens who are not able to pay for health services. As the scheme is based on means testing the declared incomes of people (entitlements exist if the income is lower than one third of the minimum wage) has to be controlled.

Under leadership of the state minister of economic relations, an economic coordination group was set up with the ministries of internal affairs, finance, labor, and social security in order to calculate the budget for the scheme. The scheme, aiming at integrating the poor into the network of social services, faced major shortcomings. Green Card holders received only care when hospitalized. They thus often delayed treatment because they were asked to do co-payments. Hospitals on the other hand, rejected Green Card holders due to delay in reimbursements by the government. Many state hospitals were reluctant to provide medical equipment, drugs, etc., for green card holders from their stock even though law required them to, and not least, the procedures for acquiring the green card was not equitable (Kisa/ Younis 2006).

4.6 Intermediate results

The incremental establishment of an administrative apparatus in the final decades of the Ottoman Empire reflected the intention to 'modernize', i.e. 'westernize' Ottoman state-structures and transform the ways in which political power was exercised. Subsequently, different policy fields and the respective ministries, equally geared to Western sectioning, were established in the Turkish Republic and meant to be structured in a more rational manner to strengthen the state by managing and steering 'the things' within it. The following decades can partly be read as the struggle between the sovereign technology of power as applied 'purest' by the sultan and the technology of discipline in the logic of raison d'état. In the 1980s and 1990s, neo-liberal governmentality was authoritatively introduced as a new technology without being comprehensively institutionalized. Traces of sovereign techniques of power such as a strongly personalized rule and 'informal' ways of ruling have pertained in Turkish politics until today.

As this chapter's overview of the historical transformation of Turkish health policies has shown, the difficulty to apply a Western state-logic and Western discourses on the reality of a peripheral, unindustrialized empire and the resulting inconsistencies between political rationalities, technologies and established state structures have impeded the crystallization, i.e. the institutionalization of what could be called a 'health care regime', understood as a legally fixed set of rules following a more or less coherent set of organizational principles.

While the Sultan had distributed services in health rather arbitrarily, presenting them as a sign of his grace, health was subsequently seen as a decisive component of a fertile and strong population which in turn constituted a strong military, a strong economy and thus a strong nation. This simple logic entailed the conclusion that the state could strengthen the nation by improving, i.e. managing the population's health. The array of means to achieve this aim included amongst others an extension of the bureaucratic apparatus and central planning, educative measures – both for health personnel and the people (hygiene) – as well as a large network of laws and regulations reaching from the licensing of drugs and contracting of doctors to the prohibition of birth control pills.

Governmental activity subsequently extended and deepened and with the incremental taking over of responsibility of curative services, social insurance, 'tested successfully in the West', was declared as the organizational principle of the Turkish health system, yet faced severe structural impediments due to the constitution of the Turkish labor market. While the establishment of the SSK, the Emekli Sandığı and later Bağ Kur entailed the emergence of privileged minorities, large parts of the population remained uninsured. Informal mechanisms, reaching from the use of the insurance cards of relatives and friends, knowing a doctor who would provide services free of charge or the relying on family and neighborhood networks, developed parallel to a fragmented and corporatist formal insurance system and a complementary tax-financed social assistance system which itself might be characterized as informal and included in many ways the exercise of sovereign forms of power (e.g. the muhtar – i.e. the head of a community - would decide who of 'his flock' is 'deserving', i.e. eligible for public assistance after closer – personal – inspection of the person's or family's living conditions).

Subsequently, the network of laws and regulations thickened, the material capacities, hospitals, health centers and other facilities, educated health personnel etc. increased and the Turkish Republic constitutionally declared itself to be a 'Social State', yet the problem of insufficient coverage persisted particularly due to the continuously high ratio of agricultural and informal labor the latter of which is estimated to lie between 25 and 50% even today (Adaman/ Keyder 2005, Buğra/ Keyder 2006, Grütjen 2008, OECD 2008: 11). A political rationale of waiting for the formal employment ratio and the amount of premium-payers to increase and the partly passive partly active support of informal mechanisms and not least a populist approach of tendering relations to certain groups that had a vested interest in the perpetuation of the status quo consolidated the dual system.

Subsequent governments, from the DP under Adnan Menderes until the ANAP-led government under Turgut Özal were concerned with extending public and curative health services by 'some sort of scheme' to the whole population. With uncontrolled rates of urbanization and the deterioration of the 'informal pillars of the developmentalist period until 1980' – 'continuing ties of newly urbanized immigrants with their villages of origin, possibilities of informal housing, and the importance of family and neighborhood assistance mechanisms' - problems connected to the lack of formal coverage exacerbated (Buğra/ Keyder 2006: 220). Insufficient formal insurance schemes, the threat of rising poverty, overburdened hospitals etc. 'led to an awareness of the social threats of a market economy that is not accompanied by sufficient security programs'. These factors led to a ‚hitherto absent consciousness of the need for social policy action' (Buğra/ Adar 2007: 11). In these circumstances the introduction of the means-tested Green Card in 1993 constituted a fourth official scheme to provide coverage to the poorest of the population.

Following Jeremy Seekings' categorization of welfare states, Buğra and Keyder have subsumed this fragmented and porous setting under the term 'inegalitarian and corporatist welfare regime' (Seekings 2005, Buğra/ Keyder 2006). While this terming aptly refers to two of the Turkish welfare – and healthcare 'regime's' main characteristics, it has to be understood as the effect of the struggle between different technologies of power and the afore mentioned complex diversity of inconsistent political projects, programs and rationalities. Particular attention must be paid to the struggle of projecting Western schemes of welfare provision, developed in the West

and based on a whole set of pre-developed state structures, state-society relations and not least emerged out of often existential societal struggles, on the Turkish Republic that had followed a very different historical transformation.

5. The Health Transformation Program

The so-called 'Health Transformation Program' was enacted by the AKP and designed on the grounds of earlier proposals and projects of the 1990s to address the above-described long-standing problems in the Turkish health sector.

By first analyzing the underlying conceptualization of health and health care and the inherent rationality that is largely shared by the World Bank and the WHO, the distinctive features of the policy field in a neo-liberal framework shall be delineated. A more detailed analysis of the actual legal and organizational changes serves to shed light on the kind and dimension of new techniques of governing the health sector and the forms of power reflected in them. Primary sources such as governmental statements or party programs, legal texts, and World Bank, OECD and WHO reports are evaluated as indicators of different rationalities. The conducted in-depth interviews with representatives of the Ministry of Development (formerly State Planning Organization), the Ministry of Labor and Social Security, with World Bank officials as well as with doctors and the general secretary of the Turkish Medical Association (TTB – Türk Tabipleri Birligi) are first and foremost used as indicators pointing to the most contested issues in the current system and raise some questions as to its stability and aspects of subjectification.

5.1 Health and health care in neo-liberal systems[12]

'Bu dönüşüm sadece Türkiye'de olmuyor. Bütün dünyada oluyor' (Yetener 2011). 'This transformation does not only happen in Turkey. It happens all over the world.' With these sentences, Dr. Müge Yetener, a physician at a private health center in Ankara started the interview. On a similar stance, Ahmet Levent Yener (2011), head of the treasury department at the World Bank office in Ankara referred to the book 'Getting Health Reform Right' as reflecting the 'flagship course of the World Bank' and not only

12 It has become a commonplace that the Bretton Woods Institutions are the main promoters of neo-liberalism on a global level. By choosing this headline and presenting the World Bank's views on health and healthcare, this thesis agrees with the standpoint that the World Bank represents a (specific) form of neo-liberalism that is however not eternal but itself subject to changes.

as 'the favorite book of the Turkish Minister of Health' Dr. Recep Akdağ but as a 'general guideline for many countries as how to initiate and implement reforms' towards 'more modern structures in the health system.'

Before analyzing the current reform program, we consider it valuable to have a glance at 'this general guideline' not only represented in the afore-mentioned book but also in various World Bank reports. Our interview partners and scholars alike have argued that the reform proposals since the 1990s and especially the Health Transformation Program have been in principle in line with the World Bank's suggestions (inter alia Akan 2011, Tatar 2006, Keyder 2005) . While our aim is not to verify or falsify that claim or in any case measure the World Bank's influence, the reports as well as the book disclose some fundamental thoughts on and dilemmas of health care policies in general and in their neo-liberal embedment in specific.

The World Bank Policy Note Turkey: Greater Prosperity with Social Justice (2003) presented a 'proposal for the 58th government' (the first AKP – election period) driven by the 'vision… of a country with greater prosperity, social justice and sustainability, that unleashes creative energy to realize its full potential' (WorldBank 2003: 4). Standing in stark contrast to many Turkish authors, the policy note starts with the assumption that the process of economic opening that had been started in the 1980s resulted in 'the average family' beginning to witness 'enormous improvements in its standards of living, opportunities, and hopes for parents and children' (ibid.: 1). These progresses had to be sustained by a 'substantial change in priorities and the way in which the state, market and citizenry interact'; reducing inequality especially in education and healthcare, establishing a system of social protection, fostering greater fiscal discipline, changing 'the relation between state and market from one granting favors to one fostering investment and competitiveness', the perception of private sector productivity rather than public spending 'as the engine of sustainable growth'. With attributing to the state the central role of setting the guidelines, the report moreover underlines that the greater reliance on market and civil society does not come along with what many call a 'minimalist government' but with one that has to supervise and regulate (ibid.: 3 ff.).

10 years before, in 1993, the World Bank had published in cooperation with the World Health Organization its annual World Development Report (WDR) on Health Care under the title 'Investing in Health. World Development Indicators'. The main objective of this

report was to 'examine the interplay among human health, health policy, and economic development as well as to set the priority policy issues and actions to be most relevant for low-income, middle-income, and formerly socialist countries' (WorldBank 1993).

According to the report, the special composition of the health sector justifies strong governmental intervention beyond the huge fields of indirect influences such as water supply, sanitation or education. Health is, similar to water, conceptualized as a 'public good' whose provision to the population has to be secured through a wide and intense set of state regulations. One reason why markets may work poorly is that variations in health risks create incentives for insurance companies to reject those who are at greatest risk and thus most in need of health insurance. A second assumption is that an unregulated private market would create 'moral hazard'[13] as costs would escalate without a promise for health gains (WorldBank 1993: 5). The lack of a natural limit on costs (since the asset being assured, the body, has no price with which costs can be compared) distinguishes health from other insurable risks.

As a consequence, 'intelligent' intervention of governments is needed in order not to 'exacerbate the problems they are trying to resolve' (ibid.). The report reveals, however, that the question most neo-liberal programs try to solve remains at the core: what is the appropriate amount and form of governmental regulation and intervention creating the right conditions for the unfolding of the context-related maximum of market mechanisms? How far can governmental activity be reduced without endangering the functioning of the market? Or, interestingly, to what extent should governmental regulation be promoted in order to secure the functioning of a 'quasi-market'?[14]

Asking which instruments would be most appropriate for affecting the behavior of insurers, providers and patients, one of the central questions is as to how far the government 'should act as an insurer, through social insurance, and how far it should regulate private insurers. These decisions comprise tradeoffs among different

13 'Moral hazard' is a term frequently used in the framework of neo-liberal policies. Whereas in the above-quoted example, moral hazard emerges in an unregulated market, the phenomenon is often presented as a negative outcome of over-dimensional state-provision of welfare services leading to a culture of dependency and the destruction of individual inventive potentials.

14 Interestingly, the promotion of stronger regulation is not limited to so-called developing countries. In the USA, which exhibits a proto-type liberal, unregulated health sector and at the same time resides among the countries with the poorest health outcomes according to WHO – standards, governmental regulation has long been a topic on the political agendas. For an interesting discussion of the largely failed reform attempts of the Clinton administration see Roberts et al. 2004: 82 ff.

objectives of health policy: better health outcomes, lower costs, more equity, and greater consumer satisfaction with the health system as a whole and with individual care' (WorldBank 1993: 73). Accordingly, there are three rationales for a direct governmental role: first, its capability to use investment in the health of the poor to reduce or alleviate poverty; second, its ability to ensure that health interventions that are public goods, such as public health information and the control of contagious diseases, benefit everybody regardless of their ability to pay; and third, its capacity to act under circumstances of uncertainty, insurance market failure, and inequities in risk and cost.

The report eventually recommends a three-pronged approach for health reform in development countries:

1. Fostering an environment that enables households to improve health
    a) Pursue growth policies that benefit the poor
    b) Expand investment in education, particularly for females
    c) Promote the right and status of women
2. Improving government spending on health
    a) Reduce government expenditure on tertiary care
    b) Finance and implement a package of public health interventions
    c) Finance and ensure delivery of a package of essential clinical services
    d) Improve management of public health services
3. Promoting diversity and competition
    a) Encourage social or private insurance for clinical services outside the essential package
    b) Encourage public and private suppliers to compete to provide inputs and services
    c) Provide information on provider performance and accreditation and on cost-effectiveness (WorldBank 1993: 72)

In 2005 "Getting Health Reform Right. A Practical Guide to Improving Performance and Equity" aimed to provide further practical advice to those 'who find themselves caught

up in health-sector reform' (Roberts et al. 2004: V). The book clearly builds up on the afore-mentioned tenets yet integrates, exceeding the newly concern for poverty reduction of the WDR, an extensive discussion about the context-related ethical dimensions of health systems while stressing the need that investments should be targeted not predominantly to single projects and programs but to the system in which those programs operate. The second part of the book defines five major 'control knobs' through which health systems might be changed: 'financing', 'payment', 'organization' 'regulation' and 'behavior' (ibid.: 153 ff.). These 'control knobs' reflect the existence of multiple dimensions reaching from structural amendments to the targeting of forms of subjectivization. While this thesis does not offer the space for a more detailed scrutiny of this book, the different 'control knobs' and with 'fine tuning' them are clearly discernible within the HTP and given explicitly as a guideline in the Health Minister's evaluation report (Akdağ/MoH 2011: 32)

Furthermore, the authors point at the complexity of questions involved in reforming the health system, often leading to a 'confused national debate':

"How should we deal with doctors' demands for more money? What strategies exist to reduce costs for medical care while expanding social insurance to cover the poor? Should we expand the system of publicly provided health centers, or move to private practice family physicians? Should we ask patients to pay more out of pocket, or make use of general tax revenues? Is the answer more technology or less? More doctors or fewer medical schools? Building new hospitals or spending more on anti-smoking campaigns?" (Roberts et al. 2004: 3)

5.2 The AKP and the social state

Even though large parts of the HTP had been drafted before the AKP was even founded, the Party under leadership of Prime Minister Recep Tayip Erdoğan was not only responsible for the implementation but, according to Ahmet L. Yener (2011), also approached and guided the process 'with a strong vision and a strong, determined minister', both decisive factors which former governments had lacked. The new political project, i.e. the general outlook of the AKP has indeed attracted a great deal of interest. The AKP was established by former members of the dissolved Welfare Party (Refah Partisi, RP) in August 2001 and has formed a to some extent original political identity which combines a liberal economic policy stance with a religious-conservative ideology. Akan argues that the new political course can best be described as

'responsible pragmatism' reflecting a flexible social policy strategy ranging between 'Islamic egalitarianism' and 'neoliberal austerity' (Akan 2011: 1).

Under the aegis of former Prime Minister Necmettin Erbakan, the RP had developed a program under which the Turkish Republic, state and society, were supposed to be reconstituted. The result was the so-called 'Just Order' which reformulated Islamic assertions along the existing conditions in contemporary Republican Turkey (Akan 2011: 5). The Just Political Order (JPO) and the Just Economic Order (JEO) were the two main pillars of the program. The JPO challenged the existing Turkish regime and the 'inegalitarian' relations it had established with diverse groups of society. Imitating 'imperialist Western countries', the elites had based their rule on clientelism and to a large extent arbitrariness, so the critique (ibid.). Instead, a state model should be erected which was to be 'in the service of civil society in its stead' (Akan 2011: 5). The JEO, meanwhile, attempted to create a middle way between (state) capitalism and socialism avoiding interest-based capital hegemony and unequal distribution of capital typical of the former and the severe decrease in productivity that came along with the latter.

The underlying rationality of state-society relations was, as Erbakan claimed, that there would 'not be poverty and starvation in the Just Order since the first and foremost duty of the state is to provide everyone with the opportunity to live in a decent way […] no matter the situation [of the economy]' (Erbakan, in: Akan 2011: 6). It was thus seen as the state's obligation to provide every citizen with an income sufficient to meet a basic standard of living. The beneficiaries were neither to be perceived as people receiving charity nor as particular groups to be privileged.

The AKP, meanwhile, attempted to reconcile the 'authoritarianism of the secular state regime and the reformist approach of the Just Order against this regime. The rather unrestrained neo-liberalization after the 1980s, the resulting inequalities, the political chaos dominated by tensions between the elitist secular regime and an upcoming movement from parties based in Islamic values, the rapid change of governments and coalitions; it was in these conditions that the JDP emerged with a more pragmatic discourse attempting to reconcile the interests of various social segments in the economic realm by developing an inclusive catch-all political strategy and the political demands of the large part of religiously sensitive in Turkey (Insel 2003: 299 ff.).

With this strategy, the JDP succeeded in garnering the votes of the long-time neglected rural population, artisans and small traders in the cities, urban slum-dwellers and emerging religious entrepreneurs running small- or medium-sized businesses. (ibid). While uncompromisingly following and implementing the IMF stand-by agreement and pursuing austere economic readjustment programs, the AKP build its party program fundamentally around the notions of 'social justice' and 'social security'.

The party program regards 'social security to be a constitutional right and considers a duty of the State to ensure that each and every citizen should benefit from this right' (AKP 2007). Yet, the way in which the AKP attends to take this responsibility is by ensuring an increase of productivity and competitiveness which in turn shall lead to an increase in social welfare. The state's function is to regulate and inspect while refraining from interventionist and populist policies. Management of social aid shall be decentralized including municipalities and non-governmental organizations in its provision (Akdogan 2006). In line with its discourse on collaborating with civil society organizations in alleviating poverty, the AKP government backed up their operations through passing 'the Law on Association of 2004' which restricted governmental control over commercial activities and encouraged private firms and companies to finance social projects in poverty alleviation through the tax incentives.

Besides embarking on a rights-based policy discourse in health care but also in social assistance, the AKP also emphasizes charity and the role of markets in order to increase efficiency. In line with the perception that Turkey had to find its position in the globalized markets, the AKP views the state as an agency which should refrain from interfering in economic activity and limit its role to regulating and monitoring private sector activity (AKP 2007).

The global discourse promoted charity and the incorporation of NGOs as a central element in social policy approaches, complementing markets and the retreating role of state agencies as service providers. This aspect did not only match the long Turkish tradition of charity foundations and especially with the AKP's social policy approach which was extensively referring to Islamic ideas on helping the poor and taking care of the needy (Buğra/ Adar 2007). The neo-liberal promotion of a minimal but universal and equal 'basic health package' is, other than in Western European countries with 'mature welfare states' also compatible with a discourse of social justice as the privileging of status groups and the large parts of the population uncovered were

conceived as an intolerable situation. While the AKP was able to rationalize and ethically justify the reforms internally, it was at the same time able to almost completely integrate international discourse and thus garner not only knowledge, expertise and consultancy but also financial assets.

5.3 The HTP – Establishing a health system

This chapter shall provide a more detailed overview of the most important aspects of the actual legal and organizational changes implemented in the framework of the HTP. At the time this thesis was written, the reform process, initiated in 2003, was already well advanced. According to interviewees at the Ministry of Development (MoD) and Ahmet L. Yener, merely the autonomization of hospitals and restructuring of the MoH into a 'planner and supervisor' and a policy developing institution stood out as facing practical problems or lacking a definite legal basis. The interviewed doctors, avowed antagonists of the reforms, also underlined the advanced stage of the implementation process. Whereas some of the program's problems and contradictions will be discussed drawing upon the interviews, the chapter will rely for the biggest part on progress and evaluation reports which provide insights into the imagination and reconfiguration of the new system and the concrete techniques applied. The stated aim of the reform packages was to ensure the delivery of high-quality, modern and effective, affordable, easily accessible health care services to all citizens. Health is conceptualized as a 'birthright' that would demand the state to assure that all people are provided with health assurance 'in line with the principles of justice and equity' (Akdağ/MoH 2011: 29). The combination of the concepts of justice and equity is indicative for an understanding of the moral basis of the transformation. Justice means equity which must be created by eradicating existing privileges and by assuring that every citizen gets access to the same amount of health care being defined in a 'basic health package'[15].

The HTP aims to achieve a transformation in the framework of eight themes:

1. Ministry of Health as the planner and supervisor
2. Universal health insurance gathering everyone under a single umbrella

15 The 1990 World Bank report 'Issues and Options in Health Financing in Turkey' targeted their advice towards 'efficiency and equity' (World Bank 1990)

3. Widespread, easily accessible and friendly health service system
    a) Strengthened primary healthcare services
    b) Effective and graduated chain of referral
    c) Administratively and financially autonomous health enterprises
4. Knowledge and skills-equipped and highly-motivated health care human resources
5. System-supporting educational and scientific bodies
6. Quality and accreditation for qualified and effective health care services
7. Institutional structuring in rational drug use and material management
    a) National Pharmaceuticals Agency
    b) Medical Devices Agency
8. Access to effective information in decision making: Health Information System

Three new topics were added with the establishment of the 60th government in 2007:

1. Health promotion for a better future and healthy life programmes
2. Multi-dimensional health responsibility for mobilizing parties and inter-sectoral collaboration
3. Cross-border health services to increase the country's power in the international arena (Akdağ/MoH 2009: 21)

5.3.1 Universal Health Insurance

A general health insurance system shall be set up in the long-term by ensuring unity in norms and standards among insurance agencies. Insurance premiums of those people who do not have solvency shall be partly or completely paid from public resources (WorldBank 2003: 155).

One of the central aims of the HTP and the basic instrument to achieve equity and access to health services was to unite the former fragmented system consisting of the SSK, Bağ-Kur, Emekli-Sandığı and the Green Card program under a newly founded single-payer, the Social Security Institute of Turkey (Sosyal Güvenlik Kurumu - SGK) (WorldBank 2004). The enrollment in this universal single-payer scheme is mandatory and contributions are paid as a percentage of the salary (OECD 2008: 44). Every

citizen was to be provided with health insurance services in equal scope and quality. Premiums for the poor would be provided by the state on the basis of a means-tested system. The 'dependent population' being the spouse and children would be covered under the membership of the head of household. Every member of this 'nuclear family' would have access to the same 'basic security package' (Günal 2008: 463). The SGK would work as the single purchaser in the health sector that contracts with public and private providers to deliver the package. The insured citizen meanwhile is, different from the old fragmented system, eligible to go to whichever doctor or hospital, private or public, he or she prefers.

The according reform steps were taken subsequently since 2003. In 2005, Green Card holders were given access to outpatient care and pharmaceuticals and thus to the same benefits as members of the other insurance schemes. In 2007, free access to primary care (see: family medicine) was granted to every citizen, even those not covered by any scheme. The Health Budget Law (Saglik Uygulama Tebligi or SUT) further harmonized benefits across the different formal health insurance schemes and the Social Security and Universal Health Insurance Law issued in 2008 completed this process by formally integrating the Green Card holders into the UHI-scheme, i.e. the SGK (Akdağ/ MoH 2011: 63 ff.). The Law fixed the premium for all insured to be 12.5% of pensionable salaries with the employer's contribution being 7.5%. In the non-contributory arm of the system, in which premiums are paid from the public budget, the law has introduced a new means-tested mechanism for the Green Card system, making eligibility for non-contributory health insurance more difficult, especially for those who had no prove of their income (Yasar 2011: 123). The part of the population that is not poor enough to be eligible for the Green Card, i.e. those earning more than one third of the minimum wage (600 TL) yet to poor to pay for sufficient treatment shall pay a reduced premium rate. This 'incentive' to get enrolled in the formal health insurance scheme is especially targeted at the informally employed workers (OECD 2008: 47).

In spite of their integration under the roof of the SGK, the three different social security and health insurance schemes have not yet been formally unified mainly due to resistance emanating from formerly privileged groups and the Constitutional Court, that had frequently taken 'an open stance in the defense of the prerogatives and acquired rights of civil servants' (Ağartan 2008). Yet, a so-called Universal Health

Insurance Fund (UHI Fund) has been implemented within the SGK. A 'claims and utilization management system called MEDULA has been established whose use in the processing of claims is obligatory to all public and private health facilities under contract with the SSI. This standardized system has 'contributed to the establishment of a virtual single-payer system' even without the UHI Law being fully implemented (OECD 2008: 47). 'Harmonization' is one of the most frequently used terms with regards to the reform and constitutes a central aspect of the re-ordering of the Turkish health. It is only in that processes are standardized, services equalized and privileges are eradicated that the field of health care is made manageable and governable by a central agency.

5.3.2 Public hospital reform and 'public enterprises' – the introduction of business models in public healthcare

The plan to decentralize hospitals had been already well advanced during the 1990s. With a plan to increase 'effectiveness, accessibility and quality of hospital services', public hospitals were to be given financial and administrative autonomous status thereby turning them into 'health enterprises' (Sarp et al. 2002: 9). According to the 'Basic Law of Health Services', enacted in 1987, 'health enterprises' were defined as 'establishments that provide health services, have public legal status, are able to meet the outcomes with their incomes, and are administratively and financially autonomous' (ibid. 11). The broad scale implementation of this hospital model had however failed for many reasons typical of the unfinished project of neo-liberalism in the 1990s; the necessary wide network of framing regulations could not be issued, the 'Ministry of Health continued its interference like appointing the staff preferred by the Ministry' or the Constitutional Court canceled some of the legislative framework given by the 'Basic Law of Health Services' (ibid. 16 ff., Barış 2011: 579 f.). Thus, in the early 2000s, public hospitals in Turkey operated as 'traditional public sector institutions', with limited financial and management autonomy. Managers had no autonomy to hire or fire staff and all staffing decisions were made by the MoH, respectively the SSK General Directorate of Health Services (for SSK hospitals). Even those hospital managers using the newly implemented instrument of revolving funds had to negotiate decisions with the MoH General Directorate of Curative Services in Ankara. Health personnel were commonly civil servants and could hardly be fired (OECD 2008a: 33)

The first step of the public hospital reform included the transfer of all public hospitals, with exception of the university and military hospitals under the roof of the MoH (Akdağ/ MoH 2011: 149). With the MoH being in charge of the hospitals, the SSK and eventually the SSI will focus on their function as purchasers. Whereas In 2004 the MoH owned and operated 57.9% of the hospitals and the SSK was responsible for 12.5%, in 2008, the MoH owned and operated 62.7%; progress in this aspect is visible but slow (WHO 2011). In a second step, efficiency in hospitals shall be increased by changing the management structure and budgeting mechanisms of hospitals The 'pilot hospital autonomy law', drafted in 2007 and still in place, foresees a 'public-enterprise' model whereby hospitals joining the pilot project would be managed by boards, while remaining affiliated to the MoH (OECD 2008); 'transfer of authority to hospitals, flexibility in management, and more autonomy over resource allocation and performance-based supplementary payment for personnel from revolving funds' (Akdağ/ MoH 2011: 150). Healthcare institutions are to become 'patient-centered service institutions' (ibid.). Shortening waiting periods which had burned itself into the public memory in pictures of overcrowded waiting rooms and waiting queues winding themselves out on the streets was one of the anticipated outcomes. Hospital employees would be no longer categorized as public employees with a right to life-long employment in the health sector but treated as privately contracted workers. Special, 'hospital-tailored' training programmes aimed at educating 'hospital managers'.

This reorganization of long established framing structures and guiding principles entails a – anticipated – massive intervention in social relations, habits and self-conceptions not only of doctors but also of patients who are planned to be given the 'status of a customer' with a right to proper service. The customer's opinion and his or her satisfaction might influence the doctors' income and the hospitals' budget which brings about a substantial shift in power-differences in physician-patient relations. While these techniques of loosening security and setting incentives aim at increasing the pressure on, or 'motivation' of the doctor to work efficiently and with high quality, the patient shall leave behind his passive role, shaping the health sector by making use of his right to make choices ('the money should follow the patient').

In the framework of this transformation, brought about and judged by principal patterns of market relations, the mandatory introduction of a 'performance-based supplementary payment system' (PBSPS) to create a 'motivated and well-performing

workforce' constitutes one of the central features (OECD 2008). Even though the MoH states that it is well aware that 'encouraging and reminding health care professionals of their responsibility for giving productive and qualified health care services…is not sufficient alone' it considers it to be a fundamental pre-condition (Aydin/ MoH 2011).

While the regular base salaries in public hospitals are paid by the MoH, the performance based additional payments are paid from revolving funds that are financed mainly from the general insurance system. The relatively autonomous hospital management can decide about how much of its budget to allocate to these PBSPS payments, within limits defined by the MoH. These limits in turn depend on a measurement of the institutional performance of health centres and hospitals. The institution is given a score based on certain indicators which defines the height of bonuses that can be distributed. The aim is setting incentives on good institutional performance and link individual with group incentives. Among the indicators are: 'access to examination rooms', 'infrastructure', 'patient satisfaction' or 'institutional productivity' (bed occupancy, average length of stay). Furthermore, individual-level performance scores are calculated for each staff member depending on the number and kind of procedures performed and employees at training and research hospitals are obliged to 'make publications of a definite number' (Aydin/ MoH 2011). By deciding upon which measurements are applicable and convenient for the Turkish case, the MoH introduces a game of assessing performance. While the choice on certain indicators and according statistical data is a rationalizing but not a neutral technique as it implies the structuring of the every-day reality of doctors and patients according to pre-assumptions about the ideal nature of this field.

As a necessary side- and framing project an all-comprehensive data-collecting and evaluation system was established. 'For regular collection of monthly data, keeping the services of employees under record, transmitting these records to reimbursement agencies and calculating the score distribution of institutions in a transparent and realistic way', hospital information systems have been introduced nation-wide.

5.3.3 Health Information System(s)

The implementation of a comprehensive information system had been part of the first projects with the World Bank in the late 1980s hinting at the impossibility to centrally steer a health system while the information is intermittent and spread over different

schemes (TUSIAD 2005). Next to legislation, the health information system has been named as one of the anchors of the overall health system (WorldBank 2003: 152).

Establishing an encompassing National Health Information System (NHIS) was a central feature of the "E-Health vision" of the HTP. Therefore, information and coding of this information, classifications and determination of terminologies were harmonized with international (most importantly EU-) standards.

The establishment of a 'Health-Net' aimed at creating a central data bank 'collecting all kind of data produced in health institutions directly and on an individual basis from where they were generated, in accordance with standards' (Akdağ/ MoH 2011: 180). A so-called Health-Net system was implemented in 2009 collecting health-related data of patients 'from birth to death'. Healthcare institutions that were integrated in the system (up to now 85% according to the MoH) are demanded to send patients' data to the system. Next to this rather invisible technique of knowing the health details of the individual to steer the whole, the captured data served to automatize processes of accounting, billing, inventory, and material management. The 'Family Medicine Information System' (FMIS) is based on the information gathered by family physicians delivering primary health care to patients. The individual's prenatal development data, birth method data and other data related to his/her birth is recorded and takes place as the first data units of lifelong health data into data center which is under supervision of family physicians. 'This health record of individual grows with him/her throughout the individual's life' (Akdağ/ MoH 2011: 181).

5.3.4 Private sector involvement or 'marketization' of health?

'In the framework of the privatization of health in Turkey, the main aim was to open Turkey's health system to the global market, to transfer health into a tradable commodity' (Yetener 2011).

The privatization and thus commercialization of health care has been one of the most contested issues in the framework of the HTP and is the focal point of the TTB's criticism of the program. Privatization may take different forms such as such as the transfer of full ownership of a facility, public-private partnerships in building and providing health services, financial support and investment schemes to private companies to encourage investment in health care or contracting-out of services such as cleaning, diagnostic or medical treatments (Ağartan 2008, OECD 2008). Dr. Feride

Aksu, General Secretary of the TTB, explained the privatization process as starting with the neo-liberal winds of change under Thatcher and Reagan, starting in Turkey with Turgut Özal and having reached its peak and institutional form now:

"In early 1990, inpatient care in the hospital, hospitals started to be commercialized in a way that the holistic health care system has been divided into different parts. For instance: Nutritive activities of a hospital, kitchen, all the food that has been given to patients and staff became a separate part… and cleaning of hospital, renovation activities, informative, computer activities, security, parking place, etc. were separated from the whole. Subcontractor firms appeared… Before 1990, we had public workers for everything but then healthcare staff started to work for subcontractors and they are not public servants anymore. They are workers of subcontractor firms…The labor regime has changed from secure to insecure modes of working. In the 2000s they started to talk about privatization of primary health care… They have transformed health center system into family health system. One physician, one nurse, they have started to work contract based… they became contract based workers, flexible health care workers and their social rights have been neglected." (Aksu 2011)

While the HTP does foresee a further outsourcing of different services and an increasing involvement of the private sector, it also aims at a clearer and stricter regulation of those facilities as regards services and pricing. The SSI contracts with private health facilities for the delivery of outpatient and inpatient health services. 'Extra billing', i.e. offering upgraded services of a higher price was allowed in order to provide incentives for the private sector in contracting with the SSI. There is, however, a strict upper limit, a 'definite cap' around 30% pricier than public facilities (OECD 2008). In February 2008, a new regulation was adopted by the MoH which will implement a 'certificate of need' requirement for new private-sector hospitals, outpatient clinics and diagnostic centers, i.e. each private facility that opens has to deliver proof of its own value in the framework of the system. Furthermore, a Public-Private Partnership (PPP) Law has been adopted in 2006 establishing a PPP-unit integrated in the MoH that was to pilot PPPs in the health sector. Amongst others, those partnerships should involve the private sector in building new MoH research and training hospitals (Akdağ/MoH 2009).

5.3.5 Other components

The primary care system was long regarded as a core problem of the Turkish health care system. Primary care usually serves as a 'gate keeper' for the next levels of the health system with doctors controlling the referrals to higher levels. The problems with overcrowded hospitals, the scenarios with people waiting in line outside the hospitals were regarded as a consequence of that weakness as people went to see hospital doctors even for minor issues.

'Family medicine' is one of the pillars of the new primary care system. Trained family doctors are paid according to the number of persons enrolled with them. In densely populated urban areas the population is assigned to specific doctors. They either work in primary health-care centers owned by the MoH or work on their own. The family doctors, too, are partly paid according to certain performance factors such as levels of vaccination rates, ante-natal visits and referrals (OECD 2008:51). Until now, the family medicine model is only implemented incrementally. 'In provinces where family medicine is under implementation, community health centres are being established. These centres provide integrated preventive, diagnostic, curative and rehabilitation services and are responsible for overseeing preventive health services such as vaccination campaigns, and reproductive and child health services. One of the main impediments to a nationwide coverage with family medicine is an enduring shortage of doctors.

National public health programmes were implemented to tackle chronic diseases, cardiac health, mental health or diabetes. Free cancer screening services were opened in 49 provinces. In 2008 the MoH issued an 'Action Plan' for the Control of Cardiovascular Diseases. The plan broached the risks connected to non-communicable diseases and tackles tobacco consumption, passive smoking, obesity and lack of physical exercise. Programmes and projects to control the spread of communicable diseases such as malaria, leishmaniasis, typhoid or tuberculosis were intensified. Vaccination and immunization programmes were expanded especially for children and the screening of pregnant women for any substance deficiencies was increased.

The reforms in primary care and public health programs are important aspects for the achievement of good health standards and the smoother processing within referral chains. Public health programs to combat communicable diseases have existed since the establishment of the Republic. While projects against tobacco consumption, obesity

or for physical exercise resemble the early promotion campaigns for hygiene, the options have broadened with the spread of mass media. The covering of 'every corner of the country' with primary health services had long been on the agenda but seems now, with the increasing budget and the thorough organization more likely to succeed.

5.3.6 Neo-liberal technology and self-discipline in healthcare

'The Ministry of Health is not a service provider anymore, it is a service purchaser and it controls the relations between the services it has bought… Everybody says that the state/government ('devlet') becomes less powerful; that it leaves the work to the market. But that's a lie; we know that because the state is undertaking everything to protect the market' (Yetener 2011).

While the MoH, as the main responsible governmental agency, is to be turned into a policy-making and regulating authority with a view to developing policies, defining standards, controlling health care providers and 'monitoring the appropriate use of resources', the reforms – as adverted to several times before – include expectations and aspirations concerning the behavior, choices, planning, working of groups and individuals (Tatar/ Kanavos 2006: 22). It seeks to influence the self-government of those actors by direct techniques of discipline (e.g. laws and regulations) and increasingly through shaping their environment in a way that makes certain choices more likely (incentives, education, comparisons according to certain standards, i.e. creating games of competition etc.).

As the angry resistance of the Turkish Medical Association against the reforms has shown, the new imaginations policy-makers draw of doctors and their self-perception and professional self-imagination stand in stark conflict to each other. The general project of taking "formal principles of a market economy and referring and relating them to, of projecting them on to a general art of government" (Foucault, see page 24 of this thesis), clearly discernible within the HTP, does not only entail the loss of security and status for physicians, it is also perceived as subjecting the physician-client relationships to the principles of a market economy.

While Enis Baris (2011) praises in his article 'Healthcare in Turkey: from laggard to leader' the 'people-centered approach' that has brought about 'pluralism, separation of power, decentralization, and competitiveness' (ibid.), doctors are warning about the consequences of the commodification of health, not perceived anymore as a 'birthright'

but as a good that one must buy on a market (Aksu 2011). Whereas the introduction of PBSPS is promoted by the MoH as raising the motivation of physicians to work efficiently and assume their responsibility to deliver good quality, Dr. Müge Yetener (2011) argues:

"Performance is used as an anesthesia to break the resistance of physicians. Everybody has to run after points to keep their jobs and survive. Performance works like that: a patient comes and you treat him: x points. Every patient is a point for me now. According to the points I'm collecting, my wage is increasing. And according to the examination and treatment I decide to give to the patient, my points are increasing… Now I will try to treat as many patients in as little time as possible and I will also try to steal patients from my colleagues... It's the same in private clinics by the way. A friend of mine performs surgeries. She has to perform a fixed amount of surgeries in a year. She couldn't do it and had to leave her job."

While the transformation has largely been perceived well by the public particularly with reference to the possibility to choose the doctor and hospital, whether public or private, freely, Dr. Feride Aksu (2011) also hints at the problematic that the 'empowerment' of the patient from suppliant to rights-endowed consumer includes. The equal access and the universal coverage are, according to Aksu, bought dearly by patients and especially by the poorest. The implementation of a 'minimum health package' as introduced by the HTP, include relatively high 'out-of-pocket-payments' for services outside this package.

All interventions which are cost-efficient are included in the package but expenses of probably necessary interventions might be excluded.

Between 2000 and 2004 an extensive study has been commissioned by the MoH and supported by the World Bank entitled 'National Burden of Disease and Cost Effectiveness Project'. Arguing that modern trends such as an 'ageing population and higher life expectancies' or a growing demand and costs for health services due to developments in science and technology lead to an increasing pressure on health budgets, a more 'rational distribution of health investments' must be achieved through an accurate identification of health needs. The study is based on the concept of 'Disability-Adjusted-Life Year' (DALY, shared by the WHO and the World Bank), that evaluates 'with a single number…both the years of life lost due to premature mortality caused by various diseases, and the disability and loss of function caused by diseases,

accidents or injuries that do not result in death' (Refik Saydam Hygiene Center MoH 2004: 6 ff.). Based on these complex nationwide calculations, the ingredients of the minimum health package were defined.

While these complex formulas represent governmental techniques to 'objectify', 'rationalize', and calculate interventions, Dr. Aksu (2011) regards them in the first place as inacceptable deep interventions into the professional authority of physicians dictating them which actions are deemed necessary in the treatment of patients and which 'superfluous' according to cost- and efficiency factors.

As an example: If I become sick and go to a hospital they might say that your treatment is included. But if your physician wants a pet scan, i.e. a whole-body-scan, they say that you can only have it once a year according to minimum health package. But your oncologist could ask two or three times. Then as a patient, I have to pay it myself or go home… or for instance a patient with cardiac pain goes to a hospital and he needs a stand. There are stands with medicine and there are only stands… If you need to put stands with medicine, your minimum package doesn't cover it. This is a big problem… Coverage of minimum health package and out of pocket payments are the most problematic areas for people.

A judgment if the HTP has created a stable system is at this time, as the implementation is still in full process, hardly possible. Yet, while the comprehensiveness of the underlying 'vision' and the decisiveness of the actual legal transformations, which are in line with international advisors and thus enjoy strong support, suggests the irrevocable character of the reforms, the destruction and attempted reconstruction of self-imaginations will further pose a central problem with regards to the questions discussed in this thesis. Further questions concerning the sufficient coverage of the poor (i.e. a sufficient minimum package), the percentage of people lacking health services due to the practice of co-payments, or ethical questions with regards to healthcare pose questions that subsequent research including quantitative studies might deal with.

5.4 Recapitulation – the governmentality of the Turkish health care system

The HTP constitutes a reaction to the long brewing crisis of the Turkish health system (chapter 4.6). As a new political actor on the Turkish stage, the AKP had pursued

partnerships with important international players such as the World Bank or the European Union and integrated their ideas into their own political agenda. Already previous to the first AKP election period, Turkish governments had accepted international standards, indicators and measurements according to which the performance of the Turkish health system was to be judged and evaluated and whose improvement formed the milestones for future reforms. New statistics and international comparisons, a new set of terminology and the awareness that the Turkish health care system would be ranked and graded on a world scale, structured the epistemic context in which the relevant actors and – with a new intensity – the AKP perceived and reacted to problems.

Seizing the window of opportunity that their subsequent election victories and their absolute majority in the Grand National Assembly presented, the AKP enacted the largest and most capacious health reform program in Turkish history. Whereas a reorganization of state-society relations according to more or less consistent principles had at large been hampered for many decades and different systems and technologies had been coexisting, often with external support, the reform agendas of the AKP government, exceeding the case of healthcare, seem to give the Turkish Republic a new structure according to principles based on neo-liberalism (chapter 3.3 – 3.4).

Whereas previous governments have assumed responsibility not only for the structuring of the health sector through laws and regulation but were also deeply entangled in the provision of the respective services, the new structure reflects the tenet to retreat from the provision while still maintaining the overall responsibility for the functioning of service provision under the proclaimed aims of ('universal') equity, effectivity and (financial) efficiency.

While the principle of equity, embedded in a discourse of social justice, is connected to the assimilation of services in a (minimal) 'basic health package' that every citizen should have the right to access, efficiency and financial soundness is to be achieved through a restructuring not only of the governments own apparatus, e.g. clearer distribution of responsibilities and centralization of information flows, but also through a restructuring of social relations in the health sector according to market principles. Hospitals are to become autonomous enterprises, doctors should work not as civil servants with fixed contracts but also work autonomous and be paid according to their 'performance' while the 'patient' becomes the 'customer' whose 'satisfaction' is to be

measured and integrated in the calculation of the health facilities' allowances and the doctors salaries. In Ahmet L. Yener's (2011) captivating words: 'the money should follow the patient'.

Thus, while possibly becoming less visible by retreating from service provision, government has to constantly create the right conditions for efficiency, competition and 'as much market as possible' by 'disposing things in the right way'. The regulation of public and private service providers is furthermore flanked by measures that should steer (i.e. influence without force/discipline) individuals in their personal choices. Projects such as anti-smoking campaigns[16] or anti-obesity programs use educative measures or the promotion of a certain live-style over all sorts of media to influence principally free citizens in their decisions and self-government. Political government thus steers not only the health system but also peoples' self-government through a sheer endless net of regulations, incentives, contracting, education, projects and campaigns.

While the state with its provider function had always been an integral part of the health system directly affected by and responsible its shortcomings, with the neo-liberal reform package, government is to become a framing activity and thus in a way more external to the health system. Put differently, and in reference to an earlier statement, government distances itself from the object of rule (i.e. the health sector with all the 'things in it') and at the same time converges towards the object by becoming concerned with lives and practices of individuals (patients and doctors) and the development of the sector as a whole.

Different from many claims that neoliberal reform is connected to the reduction of bureaucracy, state intervention and public expanses, the Turkish case witnesses on the contrary an extension of state capacity and investments to govern the sphere of health care. This interesting feature of the Turkish case can be seen as a result of the large-scale implementation of neo-liberal governmentality without the pre-existence of an extensive and thoroughly organized administrative state as in Western European, early

16 Anti-smoking campaigns are just one example of how neo-liberal governmentality, even though dominating, continues to co-exist with technologies of discipline. Whereas laws were enacted in order to ban smoking from public places and protect from passive smoking, spots in television, pictures of black lungs, babies connected to tubes in hospitals etc. are put on cigarette packs. These techniques leave the freedom of choice to individuals while affecting their perception of their own action.

industrialized states. After all, neo-liberalism needs a strong bureaucratic apparatus that is capable to create the right conditions for different market sections.

6. Conclusion

The aim of this thesis was to disclose how forms of governing the Turkish health sector in the framework of changing state-society relations have transformed in the last century. The Health Transformation Program, enacted by the Justice and Development Party under an absolute majority in parliament since 2003, constituted the focus of analysis. Special attention was paid to the political rationalities expressed in policy papers and reports as well as to the changing governmental techniques through which the health sector was meant to be restructured.

The first part of this work (chapter 2) briefly discussed the dominant approaches to welfare state research. The body of English social scientific literature particularly dealing with the Turkish health system has been expanding with the HTP but remains relatively scarce. The existing sources are for the large part concerned with assessing the health or welfare system for example with regard to its 'maturity', 'inclusiveness', 'universality' or 'social rights'. Others focus their analysis on the deteriorating impact of neo-liberalism on social policies and the welfare state at large or attempt to 'integrate' the Turkish 'welfare regime' into existing cross-national typologies.

This work attempted to rearrange and reinterpret the existing data by applying an alternative critical theoretical framework based on the lectures on the genealogy of the modern state by Michel Foucault (chapter 3). The guiding questions of how power is rationalized and exercised at specific periods in time were adjuvant in analyzing the transformation of the Turkish health system as influenced by the historically dominant forms of governing and as being composed of a multitude of different political projects under different political rationalities.

The historical account of the transformation in health policies (chapter 4) was confronted with certain inconsistencies which represented findings in themselves. It attempted to embed the analysis in the framework of a periodization geared to general shifts in socio-political and politico-economic paradigms in the Turkish Republic. Taner Akan (2011), however, argues that Turkish social policy has never exhibited any 'systematically interwoven variables' that would justify the use of Esping-Andersen's term welfare regime. Existing variables had, in fact, been constituted rather

'unsystematically and independently from each other in terms of their respective functions'. This thesis agrees with Akan as to the inconsistent and fragmented constitution of the health system until the HTP. While rationalities and rhetoric changed according to broader changes in political paradigms, an institutionalization of something that might be called a health regime or a coherent health system failed to 'materialize'.

With the founding of the Turkish Republic on the principles of a modern nation state, a bureaucratic health apparatus was constructed in order to improve the health of the population. This new awareness of the people living on the Turkish territory as a body that possesses certain definable characteristics marked the beginning of what Foucault has termed biopolitics. Techniques of sovereignty and discipline alike were applied to improve the health of the whole body whose strength was conceived of as constituting the strength of the Turkish nation.

It is no coincidence that this rationality was subject to alterations at a time when the 'Keynesian Welfare National State' (Jessop 2002) became the norm in the 'developed West'. Terms such as 'social rights' that formulated entitlements of the individual vis-à-vis the state found their way into the Turkish political discourse and concrete projects of Western stateness such as social insurance were subsequently implemented in a Turkish reality that however seemed to elude their smooth incorporation into a new system.

Up until the 1980s and beyond, the structure of the Turkish labor market had been defined by agriculture, a feature that deemed the implementation of insurance schemes financially not enforceable and at least questionable in its social necessity (WorldBank 2006). Industrialization, a politicized labor movement or traumatic experiences induced by laissez-faire liberalism had not been part of the Turkish transition and political consciousness. Groups and individuals demanding or expecting provision of extensive social security schemes by the state hardly existed within the rural Republic.

Created by a group of state actors to restore order in government to continue the planned socio-economic development of the nation, the 1961 constitution defined the Turkish state as a 'social state governed by the rule of law and based on human rights'. The actual existing policies, however, persisted to lack behind rhetoric. First insurance schemes were rather implemented under the continuing influence of a

sovereign form of exercise of power that endowed particular groups with privileges in the form of special entitlements. It thus reflects the inconsistencies within Turkish overall politics and health policies in specific, that the establishment and consolidation of a patchy and corporate arrangement was paralleled by the extension of discourses of individual and universal rights and by repeated but eventually incomplete attempts to widen and deepen state involvement in health care such as mirrored by the 'Law on the Socialization of Health Care'.

In spite of its shortcomings, the system of social protection could nevertheless be regarded as a somehow stable system as the lack of coverage in the shape of formal rules, procedures and entitlements was bolstered and even to some extent made redundant by strong informal mechanisms such as the extended family. A sort of passive social policy such as the connivance of informal housing was furthermore successful in absorbing the first more serious waves of urban migration and the social problems surfacing with it.

The emergence of neo-liberal modes of government and new political rationalities in the 1980s and 1990s put the existing mechanisms of welfare provision under pressure and thus increased the need for a formalization of procedures. Rapid urbanization, the 'nuclear family' replacing the extended family as a norm, policies of illegalizing informal housing, privatization of State Economic Enterprises, the attempted privatization of hospitals that pressurized informal, free of charge treatment etc. augmented the visibility of social problems the demand for state solutions. Especially the 1990s witnessed attempts to reorganize or create a health system that would provide at least minimal services to every citizen. The extension of the fragmented insurance system especially to the poorest part of the population was made a core issue of political agendas increasingly involving external agencies such as the WHO and the World Bank. Not least due to the continuing practices of clientelism, corruption, the resistance of groups that feared a loss of their privileges and because of persisting political tensions, the comprehensive institutionalization of a neo-liberal agenda remained, apart from the introduction of the Green Card scheme, limited.

As the analysis of the HTP has illustrated, the neo-liberal restructuring of the health care system under the opportune political conditions of the single-party rule of the AKP witnesses a hereto unseen degree of institutionalization. As mentioned in chapter 3, Foucault defines the problem of neo-liberalism as "… how the overall exercise of

political power can be modeled on the principles of a market economy" or how to take the "formal principles of a market economy and referring and relating them to, of projecting them on to a general art of government" (page 21). This attempt to actively restructure a defined space according to principles of a market economy, which – 'in nature' – would not allow for a 'free market', is clearly discernible in the retracing of the reform package's single components (chapter 5.3). The efforts to establish an insurance system which is financially sound, sustainable and efficient come along with a thorough rearrangement of social relations and the projection of economically defined subjectivities. Hospitals are supposed to become public enterprises; doctors are to become managers, patients are to become actively involved in the managing of their own bodies. Responsibility and competition pervade the reforms as fundamental principles while (or with) social security, for doctors as well as for patients, is guaranteed by the state only on a minimal level.

Rather than heralding a retreat of the state, the neoliberal governmental technology signifies the organizational and regulative encroachment upon the interplay of actors within the health system. The introduction of a GHI scheme, the introduction of family medicine, the control of health spending through introduction of new payment mechanisms, new controls on pharmaceuticals, the preparation and partial implementation of hospital autonomization, the subsidization and simultaneously increasing regulation of private practice, the abolishment of civil servant statuses of doctors, the 'rational' definition of a minimum package and the privatization of everything exceeding it, etc.; all these measures reflect the central role of government thoroughly and constantly framing the course of action that is defined by a rationality that sees justice as creating equality of treatment at a low level while not only individual responsibility but especially the continuous importance of non-governmental support schemes and the family are promoted as the 'natural' Turkish complementation to a state that 'formalizes' organization while extinguishing privileges. It is to a large extent due to the long developed fragmentation and the in fact non-existence of what could be called a health-regime that, other than governments of states with a long tradition of public welfare, the AKP was successful in publicly promoting neo-liberal reforms in the health sector in combination with a discourse of social justice.

6.1 A personal remark

After our interview, a physician active in protests against the HTP told me that she had gained the impression I was not critical enough of the trends of marketization and the commercialization of health or the taking away of the peoples' natural 'birthright' to health. On the one hand, I felt satisfied with my questions as my plan had been to avoid any preoccupation with value-laden and 'pre-forming' vocabulary. Yet, at the same time, her comment raised the legitimate question as to how far a theoretical framework which is critical in an academic sense might be a basis for critique in a political sense.

Neo-liberalism in and outside of health care must be seen as a powerful paradigm exactly because it is designed to penetrate state-society and inter-societal relations according to at least theoretically rather simple principles.

We consider it as a necessary 'first step' to get a grasp of this profoundness of the neo-liberal paradigm and its complex workings and procedures within a specific context. Particular the focus on the aspect of subjectivity and the avoidance of simple dichotomies draw our attention to our own – active – role within neo-liberalism and might make us aware of the discrepancies between governmental rationalities, their workings on us and our personal imaginations of our own lives. It is this increased consciousness for our involvement in a system that might provide the ground for a clearer and more purposeful formulation of critique. This, however, must and hopefully will be part of further work on the government of health.

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